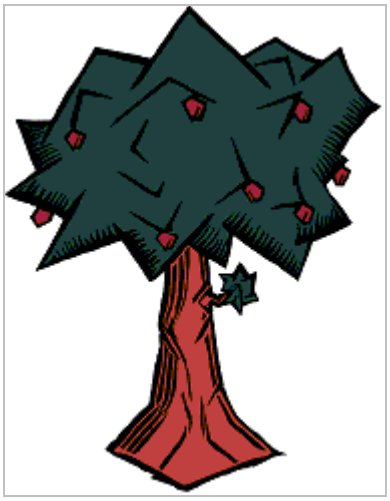
State of Washington

Department of Social and Health Services



MMIS Business and System Requirements Analysis Project

Business Process Review Report

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Revision History

Version #	Date	Revised By	Revision Description
Draft 0	12/30/2003	Tina Murdoch	Initial Draft
Draft 1	1/13/2004	Tina Murdoch	Stakeholder comments incorporated
Version 1	2/20/2004	Mike Lasher	Final comments/revisions included.
Version 2	3/4/2004	Mike Lasher	Modifications to comments on Version 1 from MMIS Services and DMM.

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1. Executive Summary

1.1 Project Overview

The Washington MMIS Business and System Requirements Analysis project is the first step in the Medicaid Management Information System (MMIS) re-procurement process. The Department of Social and Health Services (DSHS) and FourThought Group will work together to discover, analyze, and document the state's current and future Medicaid business practices and system needs. At the highest level, the scope of this project is defined by the following project objectives:

- Document the current technological and organizational environment.
- Identify high-level issues with the current MMIS and the high-level needs for the future system.
- Identify the functional system requirements for the future MMIS.
- Analyze alternatives and recommend a future technological infrastructure development strategy.
- Analyze alternatives and recommend a future MMIS procurement strategy.
- Analyze the current state of the Medicaid Medical Eligibility Determination process in DSHS and recommend a future direction for that process.
- Perform a Business Process Review (BPR) for four functional areas of the Medicaid program: MMIS services, Claims Processing and Adjudication, Prior Authorization, and Provider Enrollment.

DSHS has the option of extending the project to include two additional objectives:

- Development of an Advanced Planning Document (APD).
- Development of a Request for Proposal (RFP) for the selected procurement option.

These objectives were derived from the project requirements specified in the Request for Proposal (RFP) developed by DSHS and the proposal submitted by FourThought Group in response to the RFP. Some objectives were derived from additional service contracts awarded after the initial contract. Fulfilling the objectives of this project will establish the basis by which the state can make sound Medicaid technology investments in the future.

1.2 Introduction

The Washington Department of Social and Health Services (DSHS) began the process of procuring a new Medicaid Management Information System (MMIS) with the MMIS Business and System Requirements Analysis project. As part of this project, FourThought Group has performed a business process review of four functional areas within the Medical Assistance

Administration (MAA). These functional areas include: MMIS Services, Claims Processing and Adjudication, Prior Authorization and Provider Enrollment. The business process review began by interviewing MAA staff members in order to define the current business practices. Those practices are documented in the narratives and diagrams of this report. In addition, the report contains recommendations on how each functional area can improve its business processes to support the new MMIS. These recommendations have been documented in a separate Appendix that is not included in this report.

2. MMIS Services

2.1 Organizational Overview

The MMIS Services section is part of MAA's Information Services Division and is divided into two separate functional teams based on their primary responsibilities. The Eligibility Services team is responsible for making sure that all of the eligibility information for Medicaid claims is concurrent and accurate. Even though the MMIS and the Automated Client Eligibility System (ACES) are the primary systems used to store this eligibility information, the Eligibility Services team often works with other systems and interfaces that may involve eligibility data accuracy.

The remainder of the staff within MMIS Services is responsible for the system needs of all DSHS Administrations utilizing the current MMIS. This includes, but is not limited to, making determinations regarding the impact that Program Billing Instructions and the WAC (Washington Administrative Code) could potentially have on the MMIS, as well as a wide variety of professional review services. The MMIS Services Staff also attend high-level internal and external meetings regarding Medicaid Policy and assess the scope of all system changes to the MMIS and all of its interfaces with other systems.

2.2 Overview

Due to the difference in functions and processes between the teams within the MMIS Services Section, the business processes have been separated within this document. The Eligibility Services team, although part of the MMIS Services organizational unit, have completely different priorities and responsibilities. For the purposes of this document, the Eligibility Services team and MMIS Services are described as separate functional areas.

Throughout this section the term "program" is used to describe any of the Medicaid (federal and state funded), Medical Care Program (state administered), and Children's Health Insurance Program (CHIP, federal and state funded) programs, which currently utilize the MMIS for Medical Assistance administration.

2.3 Business Functions

2.3.1 Eligibility Services

The Eligibility Services Team's processes are for the most part, centered on monitoring the interface between the ACES and the MMIS. The MMIS generates edit reports compare eligibility records between the ACES system and the MMIS. Since the ACES system has limited capabilities for the verification and editing of eligibility records, compared to the MMIS, it is necessary to monitor Clients who are accepted by the ACES system but rejected by the MMIS.

It is also necessary to compare the ACES eligibility files to the MMIS, to catch any changes that did not create a "trigger record" to be sent to the MMIS. These trigger records are created by the ACES system whenever a change, addition or deletion occurs. ACS reports each trigger record from the ACES system, electronically, so that they can be uploaded into the MMIS.

The Eligibility Services team also handles incoming phone calls, faxes and emails from Medicaid Providers or Pharmacies that are attempting to fill prescriptions for Medicaid Clients and are receiving denials for eligibility. The team's primary responsibility is to make sure that eligible Medicaid Client records are correct in the system so that authorizations can be processed and claims can adjudicate correctly. The summaries below divide the Eligibility Services team's functions into two primary categories, Eligibility Discrepancies and Pregnancy Report Processing.

2.3.1.1 Eligibility Discrepancies

ACS runs a nightly extract of the ACES eligibility system. Any changes, additions and/or deletions create a trigger record that is reported on an electronic file. ACS pulls the trigger record file and uploads it nightly into the MMIS, so that any eligibility changes can be incorporated. Since the ACES system and the MMIS do not have the same system edits, a daily report is needed to catch any discrepancies. The Eligibility Services team processes the report, titled "Eligibility Reject Report", on a daily basis.

A second process, that occurs monthly, utilizes the "ACES to MMIS Reconciliation Report" to compare the Client records in the MMIS to those in the ACES system. The intent is to assure concurrency between the two systems and to compare active Client records in the MMIS with the same Client records in the ACES system.

2.3.1.1.1 Nightly Eligibility Updates

Nightly, ACS accesses the ACES eligibility data for trigger records. ACS loads the trigger records into the MMIS. Any data with errors, such as duplicate or mismatched social security number, invalid date, or mismatched name or birth date, is rejected. ACS compiles the results that rejected, electronically, and lists them on the "Reject Report". ACS routes this report to the Eligibility Services team for research.

The Eligibility Services team researches the Reject Report daily. This process begins with the team researching the ACES system to see if there are any narrative indications on the Client's record. The team determines whether the issue can be resolved immediately, or if the local office needs to be contacted for further research. If the local office needs to be contacted, the team makes an entry into the "local office contact" database which sends an automatic email to the local office. Once the local office has researched and resolved the issue in the ACES system, they communicate the result back to the team. Once the details are received, the team updates the MMIS eligibility information.

The most common reject error results from mismatched Social Security Numbers (SSN). When program enrollment requires disclosure of the client's SSN, ACES performs a nightly SSN verification process. Errors to SSNs are identified and subsequently corrected. However, this SSN correction process occurs after the ACES interface to MMIS. If MMIS had a previous eligibility record for this client with the correct SSN, MMIS would also identify the incorrect SSN on the Nightly Reject Report. When the corrected SSN is passed on a subsequent eligibility file, this corrected record is identified as a mismatch to the previously passed incorrect record.

Currently, the Eligibility Services Team identifies SSN mismatch as the highest reject error on the Reject Report. The staff is able to research and resolve the majority of these errors by researching the SOLQ database. Unresolved SSN mismatches are returned to the local office. On a monthly basis, the Eligibility Services Team returns 10 – 180 mismatched to the local office for additional research and follow up.

The Eligibility Services Team reports that name mismatches are also common and are generally the result of typographical errors. These errors are also returned to the local office for correction.

2.3.1.1.2 Monthly Eligibility Reconciliation

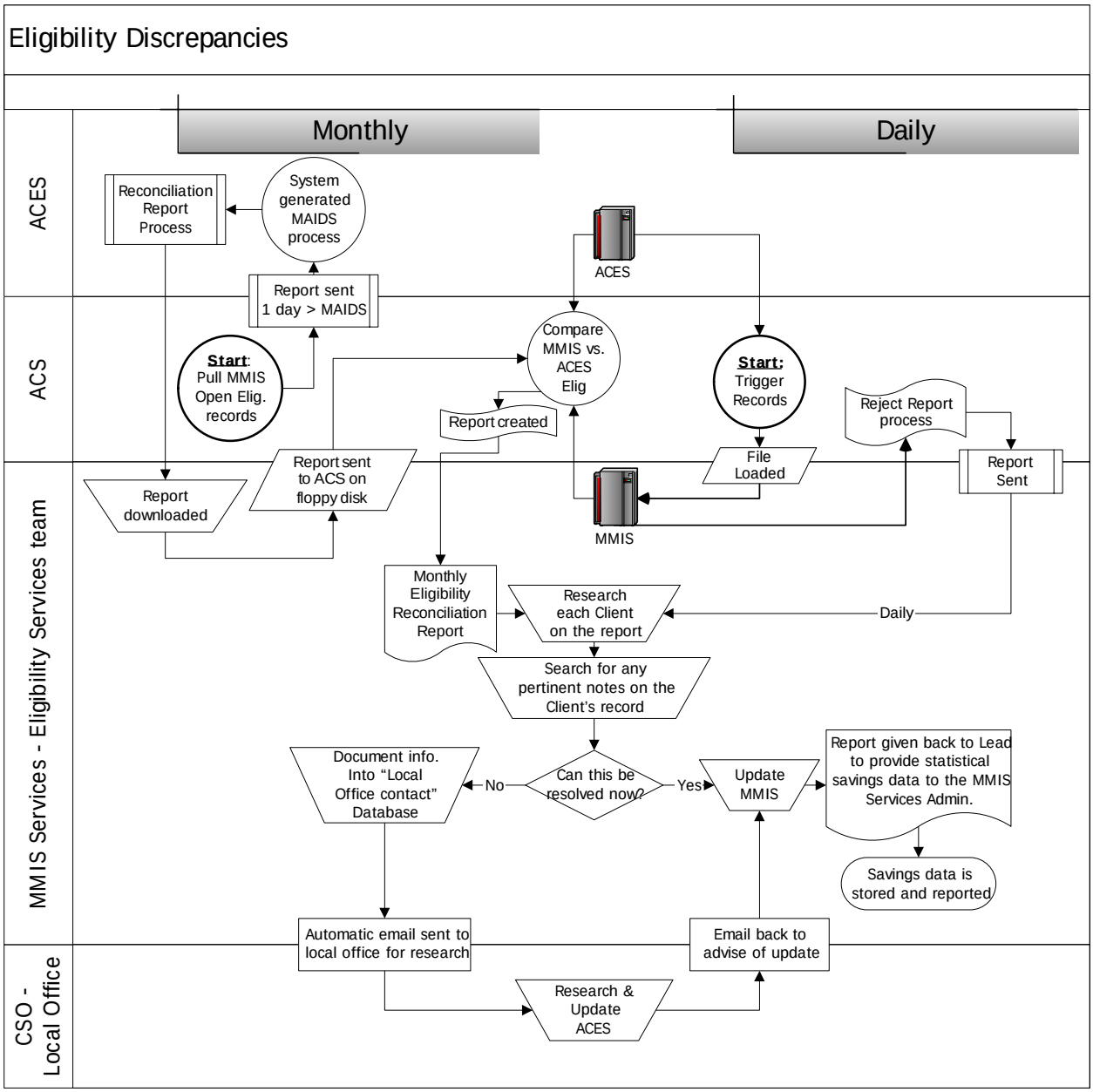
On a monthly basis one day prior to the generation of the Medical Assistance Identification card (MAID), ACS extracts all open eligibility records and corresponding client information from MMIS related to Third Party Liability (TPL), Managed Care (from the Primary Care Options Program, PCOP, segments), Division of Developmental Disabilities (DDD) or Medicare. This file is sent to ACES and the corresponding client information relating to TPL, PCOP, DDD or Medicare is merged with ACES eligibility to be printed on the monthly MAID cards. Any records that ACS sent to ACES that have no current coverage in the ACES system are identified and compiled into a list. Once the list is completed, the ACES support staff post the list to their website.

The Eligibility Services team leader downloads the list posted by ACES support staff and forwards the data to ACS on a floppy disk. ACS compiles the monthly list and all open eligibility files from the MMIS and the ACES system together for creation of the "ACES to MMIS Reconciliation Report". ACS sends the report to the Eligibility Services team leader, who divides it out to the team, so that each discrepancy can be researched.

The Eligibility Services team researches the MMIS and ACES systems for each Client on the Reconciliation Report, to investigate any notes or other information that may resolve the discrepancy. If the local office needs to be contacted, the team makes an entry into the "local office contact" database which sends an automatic email to the local office. Once the local office has researched and resolved the issue in the ACES system, they communicate the result back to the team. Once the details are received, the team updates the MMIS and hand writes any corresponding notes on the report. The team leader compiles the Reconciliation Report data and records the statistical information into an Excel file used for calculating savings and other MAA analysis reports.

2.3.1.1.3 Eligibility Inquiries

The Eligibility Services team receives inquiries from providers and pharmacies to verify client eligibility. Often, clients are deemed eligible and are in need of services on that same day. The local office issues an eligibility card (MAID) to the client and, in turn, the client presents this card to the provider. As MMIS and POS eligibility have not been updated, the providers are unable to verify eligibility. In the case of the pharmacies, they are unable to process claims for that client until eligibility is updated in the POS. In this instance, the pharmacy calls or faxes a request to the Eligibility Services Team. Upon completion of research, the Eligibility Services Team manually builds eligibility for this client in both the MMIS and POS. On a daily basis, MMIS Services receives an average of 60-90 fax requests for eligibility from pharmacies.



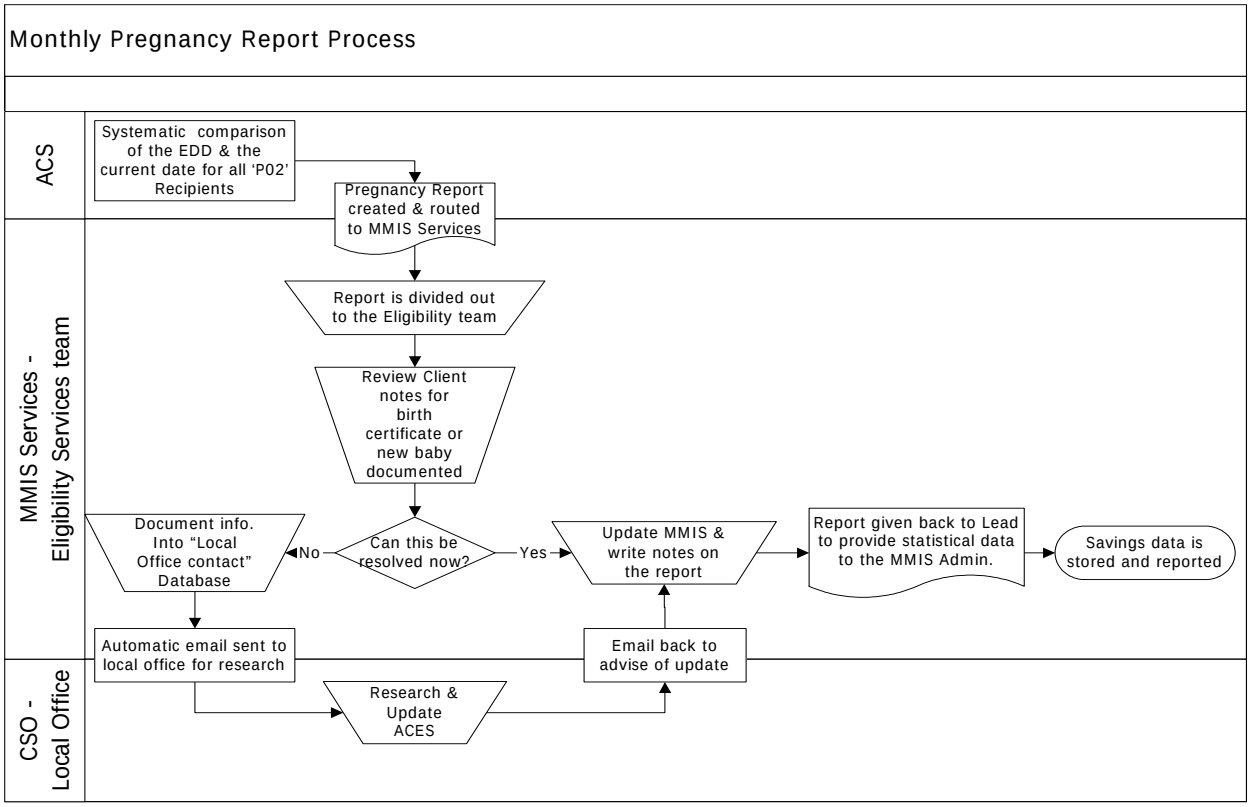
2.3.1.2 Pregnancy Report Processing

Similar to the monthly Reconciliation Report, ACS also performs another systematic comparison of the ACES and MMIS systems, specific to Clients on the Pregnancy Plan (eligibility code P02), with an EDD (estimated due date) sixty days past the current date. Pregnant Clients are required to report their delivery to the local Medicaid office within sixty days, so that the local office can move the Client off of the pregnancy plan. If this notification does not occur, the Client's eligibility premiums are calculated incorrectly.

In an effort to correct this issue, MMIS Services and ACS have developed a comparison process that systematically produces a monthly "Pregnancy Report". ACS provides MMIS Services with this report so that they can identify and resolve members incorrectly enrolled on the Pregnancy Plan, need to be moved to the Family Planning Only Program, or are no longer Medicaid eligible.

Monthly, ACS systematically compares the EDD to the current date, for each Client on the pregnancy plan in the MMIS. If the EDD is sixty days or more prior to the current date and the eligibility segment is still active, the Client's information is added to the Pregnancy Report. ACS compiles the Pregnancy Report, monthly, and forwards it to the Eligibility Services team. Once the report is received, the team lead divides it out to the Eligibility Services team for research.

The Eligibility Services team researches the MMIS to determine if a delivery has been recorded. The team also reviews the notes in the ACES system to see if a birth certificate copy has been received or if a new baby's information is referenced. Based on this review, the team determines whether the issue can be resolved. If the issue cannot be resolved, the team makes an entry into the "local office contact" database which generates an automatic email to the local office. Once the local office has researched and resolved the issue in the ACES system, they communicate the result back to the team. Once the details are received, the team updates the MMIS and hand writes any corresponding notes on the report. The team leader compiles the Pregnancy Report data and records the statistical information into an Excel file used for calculating savings and other MAA analysis reports.



2.3.2 MMIS Services

A primary function of the MMIS Services Section is to provide MMIS support for problems and questions and act as a liaison between DSHS and ACS. Since each DSHS organization has some individuality, the MMIS Services individuals are specialized to provide customized support; however, they perform similar processes that are dependent upon the nature of the request. Examples of MMIS Services support are a) A Program Manager needs a CSR (Computer Service Request), b) CMS (Centers for Medicare and Medicaid Services) requests a quality review of claims adjudication (CPAS), c) Medicare, Department of Health (DOH) and Department of Labor and Industries (L&I) request a review regarding format policy and system parameters or d) New legislation creates a need for a new claim edit. MMIS Services has provided the MMIS user community with a chart detailing who to contact for the various DSHS services, but if a user does not contact the correct MMIS Services staff, they will be directed to the appropriate one immediately.

2.3.2.1 CSRs and ACS Work Requests

A CSR and an ACS work request are very similar in form and purpose. They are both used to request ACS support for the MMIS, however; not all requests for MMIS support end up as a CSR or ACS work request. The requester can complete both of the forms, but most often, MMIS Services receives an email, phone call or other communication from a requester and then complete the appropriate form. The difference between the two requests are that a CSR is used for changes, updates or deletions to the MMIS; whereas, an ACS Work Request is a complex issue or question that the MMIS Services Staff may not be able to answer. Any time that the MMIS has been modified, a System Testing process occurs, but since this is a separate process; it is described in the next section.

Since the pharmacy (PBM) coverage is administered through the POS MMIS and their issues are processed by separate support staff at ACS, the forms for the POS MMIS are completed and prioritized by the MMIS Services Pharmacy Program Services team.

When a problem, update, change or other MMIS system related request is identified and MMIS Services determines that a CSR or ACS work request form needs to be completed, the MMIS Services Staff work with the requester to complete the details for the form. The MMIS Services Staff communicate with the requester about the desired end result. At this point, the MMIS Services Staff saves the electronic version of the request on the MMIS Services secured drive and routes it to the MMIS Services Administrative Assistant. The MMIS Services Administrative Assistant assigns a record control number, documents the request into the master record log and prints out the form for the MMIS Services Manager to approve and sign. The MMIS Services Manager reviews the request with the established priority guidelines and the ACS liaison to determine a priority and completion time frame. The Manager then routes the request to ACS.

The ACS liaison receives the CSR or ACS work request and adds it to their issue tracking and reporting system. This system assigns a CSR number and adds it to the “CSR List Report”. The

MMIS Services Staff review the CSR List Report during the weekly status meetings for all open CSRs, PBM CSRs and ACS work requests. During this weekly meeting, with the ACS liaison, the MMIS Services Staff receive status and discuss questions and issues on the open requests.

ACS programmers process the request and load any changes into the MMIS test environment. Once ACS tests the changes, the liaison notifies the MMIS Services Staff. At this point, the MMIS Services Staff notifies the requester and determines who will participate in the System Testing process, which, since it is a separate process in itself, is described separately in this document.

2.3.2.1.1 Post System Testing

Once the MMIS Services Staff has completed the testing and ACS has loaded the changes into the MMIS production environment, the MMIS Services Staff communicates the updated status to the ACS Liaison. The ACS Liaison changes the CSR status for the CSR List Report to "completed", which remains the same until the CSR is removed from the report. The MMIS Services Administrative Assistant contacts the requesters on a weekly basis to verify if the issue is completely resolved. For those that are resolved, the MMIS Services Administrative Assistant compiles them on a memo to the ACS liaison during the weekly priority meetings. The ACS liaison removes the "closed" requests from the CSR List Report.

2.3.2.2 System Testing

The MMIS Services Staff is responsible for ensuring that the MMIS is accurate and efficient. This responsibility can include CSR created modifications, enhancements, interfaces to other systems, Program policy application, etc. During any system modification process, the MMIS Services Staff receive notification that ACS has loaded the requested changes into the test environment. The MMIS Service Staff are responsible for testing both the test and production environments and encourages the requester to participate with testing, however; due to the complexity and time requirements involved with testing, the requesters often bypass their involvement and rely on the MMIS Services Staff to complete it for them. For these same reasons as well as the fact that the test environment is not in real time with the production system, the MMIS test system is only available in the MMIS Services area.

The POS MMIS has different functionality as well as different support staff at ACS. MMIS Services Pharmacy Support staff is responsible for both the test and production environments, and they can request changes to be made in the production environment for a quicker testing turn around time. Due to these differences, the business process flows have been separated below.

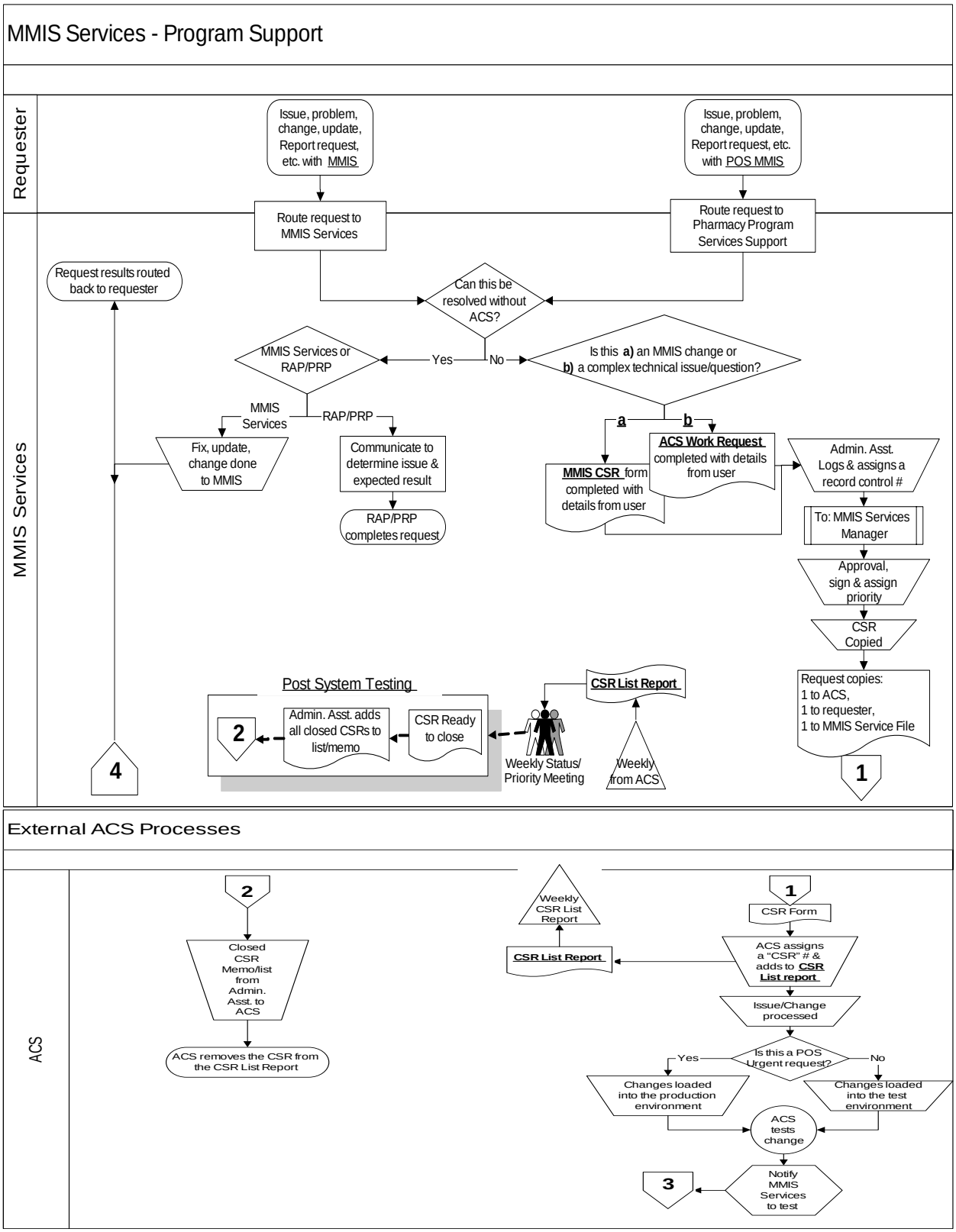
2.3.2.2.1 MMIS

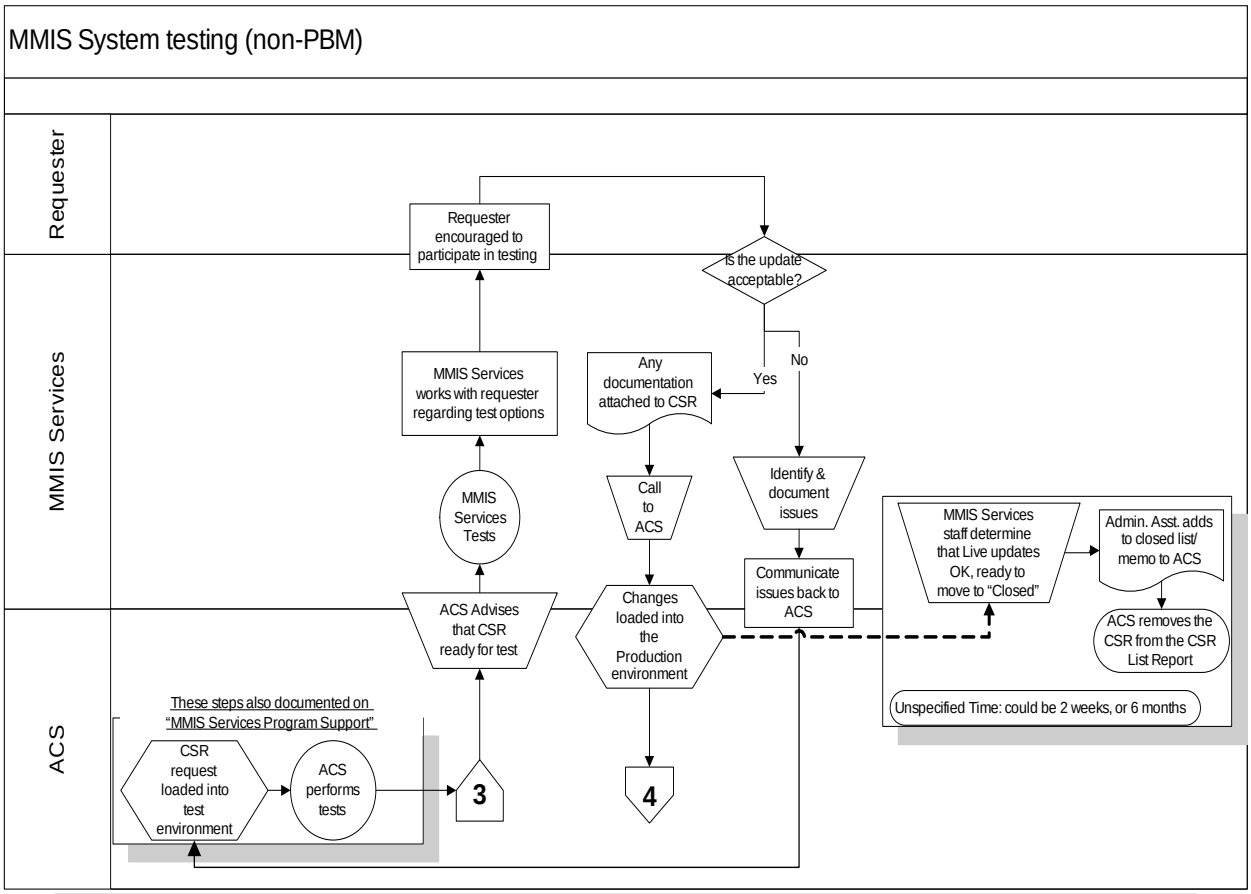
ACS Representatives process CSR requests and load the changes into the test environment of MMIS between the end of business hours on Friday through the end of business hours on Monday. The ACS liaison tests the changes and determines if the request is complete. The

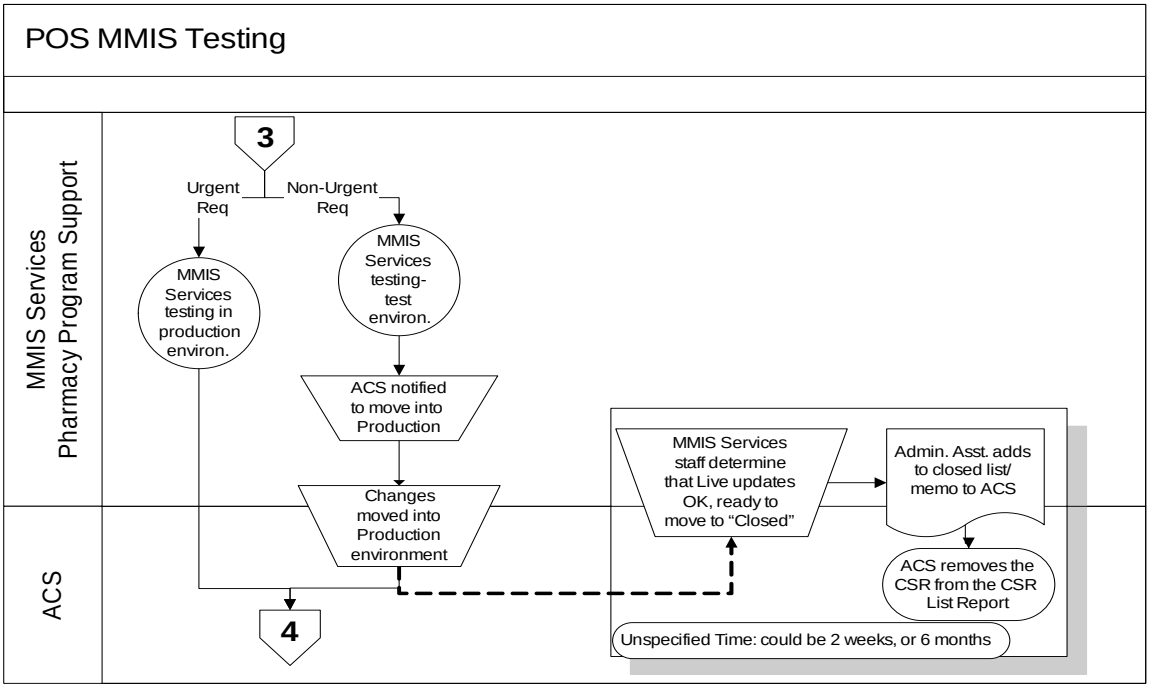
ACS liaison telephones or emails the MMIS Services staff to notify that the requested changes have been loaded into the test environment. The MMIS Services Staff tests the changes between Tuesday and Friday and any decision to move changes into the production environment must be made prior to Friday's end of business hours. The MMIS Services Staff contacts the original requester to notify that the request is ready to test, and encourage participation, but don't require the requester to attend. During testing, if the changes do not satisfy the original request or are incorrect, the MMIS Services Staff contacts the ACS liaison to notify of the issue. Once confident that the changes satisfy the request, the MMIS Services Staff contacts the ACS liaison by telephone or during the Thursday status meeting, to have the changes moved into the production environment. After ACS moves the changes into the production environment, the MMIS Services Staff retest the changes now in production. If all of the changes are correct, MMIS Services contacts the ACS liaison to have the CSR status changed to "complete". Once the CSR request is satisfied, the system testing process is complete and the CSR Post System Testing process continues.

2.3.2.2.2 POS MMIS

Since the POS MMIS operates in a real time environment, the actual system testing can be done either in the test or production environment, dependent upon urgency. ACS programmers process CSR requests and load the changes into the appropriate environment. The ACS liaison tests the changes and determines if the request is complete. The ACS liaison telephones or emails the Pharmacy Program Services Team to notify that the testing has been completed successfully. The Pharmacy Program Services Team tests the changes and contacts the original requester to notify that the request is ready to test, and encourage participation, but don't require the requester to attend. During testing, if the changes do not satisfy the original request or are incorrect, the Pharmacy Program Services Team contacts the ACS liaison to notify of the issue. Once confident that the changes satisfy the request, the Pharmacy Program Services Team contacts the ACS liaison by telephone or during the Thursday status meeting, to have the changes moved into the production environment, if not already in the production environment. After ACS moves the changes into the production environment, the Pharmacy Program Services Team retests the changes now in production. If all of the changes are correct, Pharmacy Program Services contacts the ACS liaison to have the CSR status changed to "complete". Once the CSR request is satisfied, the system testing process is complete and the CSR Post System Testing process continues.


MMIS Services - Program Support
Requester
MMIS Services
Issue, problem, change, update, Report request, etc. with MMIS
Issue, problem, change, update, Report request, etc. with POS MMIS
Route request to MMIS Services
Route request to Pharmacy Program Services Support
Request results routed back to requester
Can this be resolved without ACS?
MMIS Services or RAP/PRP
Yes
No
Is this a) an MMIS change or b) a complex technical issue/question?
MMIS Services
RAP/PRP
Fix, update, change done to MMIS
Communicate to determine issue & expected result
RAP/PRP completes request
a
b
MMIS CSR form completed with details from user
ACS Work Request completed with details from user
Admin. Asst. Logs & assigns a record control #
To: MMIS Services Manager
Approval, sign & assign priority
CSR Copied
Request copies: 1 to ACS, 1 to requester, 1 to MMIS Service File
1
Post System Testing
2
Admin. Asst. adds all closed CSRs to list/memo
CSR Ready to close
Weekly Status/ Priority Meeting
CSR List Report
Weekly from ACS
4
External ACS Processes
ACS
2
Closed CSR Memo/list from Admin. Asst. to ACS
ACS removes the CSR from the CSR List Report
Weekly CSR List Report
CSR List Report
1
CSR Form
ACS assigns a "CSR" # & adds to CSR List report
Issue/Change processed
Is this a POS Urgent request?
Yes
No
Changes loaded into the production environment
Changes loaded into the test environment
ACS tests change
3
Notify MMIS Services to test


MMIS System testing (non-PBM)
Requester
MMIS Services
ACS
Requester encouraged to participate in testing
Is the update acceptable?
No
Yes
Any documentation attached to CSR
MMIS Services works with requester regarding test options
MMIS Services Tests
Call to ACS
Identify & document issues
Communicate issues back to ACS
MMIS Services staff determine that Live updates OK, ready to move to "Closed"
Admin. Asst. adds to closed list/ memo to ACS
ACS removes the CSR from the CSR List Report
Unspecified Time: could be 2 weeks, or 6 months
ACS Advises that CSR ready for test
Changes loaded into the Production environment
These steps also documented on "MMIS Services Program Support"
CSR request loaded into test environment
ACS performs tests
3
4


POS MMIS Testing
MMIS Services Pharmacy Program Support
ACS
3
Urgent Req
Non-Urgent Req
MMIS Services testing in production environ.
MMIS Services testing-test environ.
ACS notified to move into Production
Changes moved into Production environment
MMIS Services staff determine that Live updates OK, ready to move to "Closed"
Admin. Asst. adds to closed list/ memo to ACS
ACS removes the CSR from the CSR List Report
Unspecified Time: could be 2 weeks, or 6 months
4

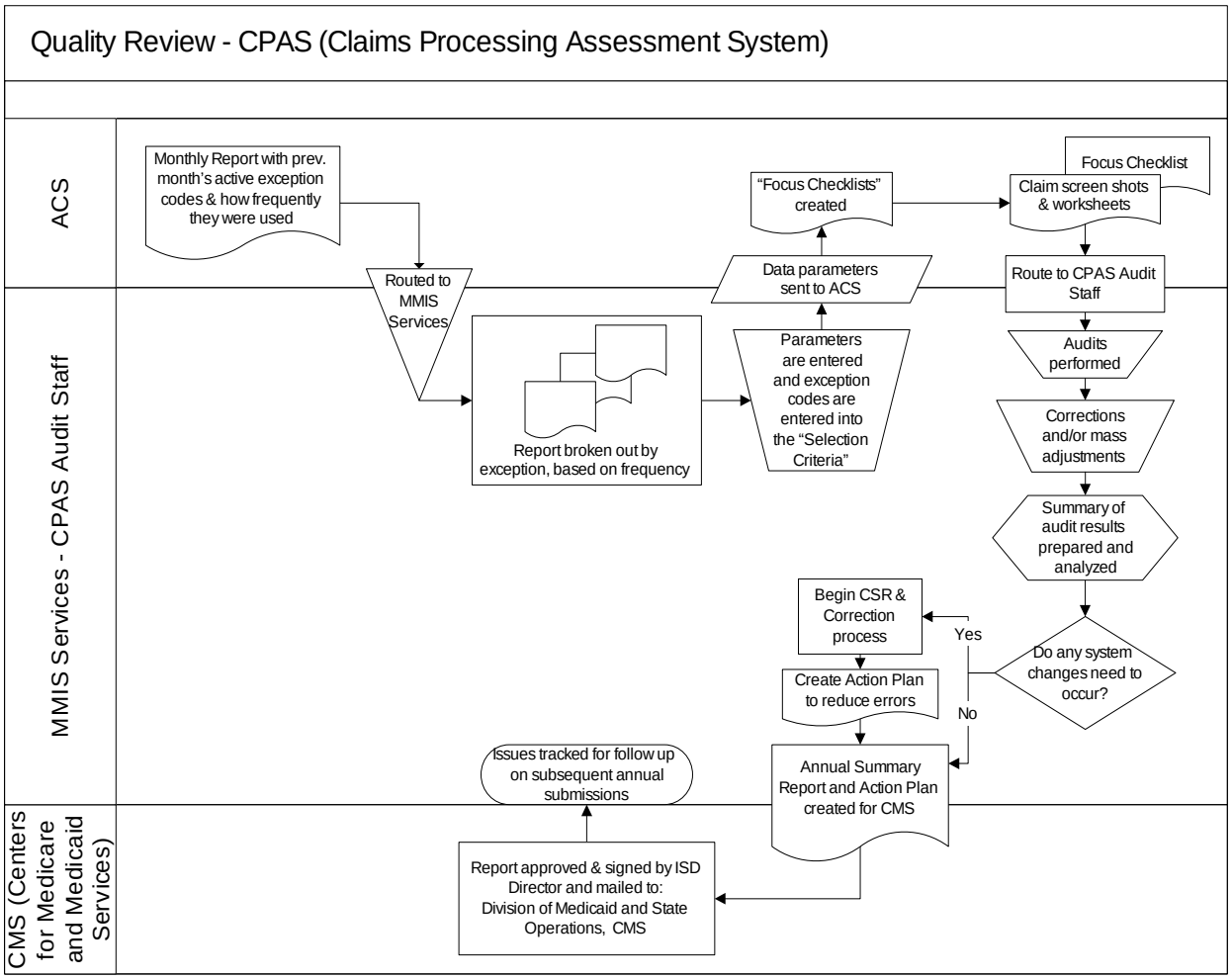
2.3.2.3 Quality Review - CPAS

The Claims Processing Assessment System (CPAS) is a process designed to pull five system audits based on claim criteria, post adjudication. The CPAS process utilizes system programmed exception codes that, based on claim criteria, are assigned as the claim routes through the adjudication process. In order to improve upon the quality of claim adjudication, CPAS provides DSHS with a measurement and analysis tool. The MMIS Services CPAS Audit Staff produce an annual report containing the results of the monthly CPAS and an action plan for the following year, as required for federal review by the Centers for Medicare and Medicaid Services (CMS) and Code of Federal Regulations (CFR).

On a monthly basis, the MMIS Services CPAS Audit Staff receives a report from ACS that details all of the active claim exception codes and how frequently they occurred for the previous month. The CPAS Audit Staff divide the report by exception code, and prioritize the codes by frequency, so that an adequate number of claims for each edit can be audited. From the MMIS main menu, the CPAS Audit Staff select option '3' for Claims Control File. The CPAS Audit Staff then enters the criteria selected for the audit. The criteria are sent automatically to ACS for creation of the "focus checklist", for each claim that falls within the selected criteria.

ACS routes all of the relevant claim information, based on the PDDD (Procedure, Diagnosis, Drugs and DRG) reference tables in the MMIS that are needed for the audit (including screen shots of the claims) back to the CPAS Audit Staff. The focus checklist and attachments are intended to be a quick and easy way to audit large claim volumes. The CPAS Audit Staff should not need to access the MMIS to perform the audit, unless questioning the validity of the documents provided by ACS. The CPAS Audit Staff summarizes and reviews the audit results to determine whether an error has been made. If an error is identified, the CPAS Audit Staff forwards details to the appropriate MMIS Services Staff to conduct research, correct the error, verify with a supervisor and conducts training as needed. If the CPAS process stimulates a need for a CSR, the CPAS Audit Staff work with the appropriate MMIS Services Staff to complete the CSR. The CPAS Audit Staff summarizes these 'actions' on an annual basis for CMS and provides the following reports:

- CPAS Error Summary Report
- CPAS Analysis Report (audit statistics and corrective action measures for each)
- CPAS Focus Review Summary
- CPAS Claims Accuracy Review Summary (which contains a CFR required, 42 claim sample for each quarter)
- CPAS Quarterly Elapsed Processing Days Review (database and analysis used to assess timeliness of payments)
- CPAS Timely Claims Processing (Monthly record of the days between the date of receipt and the check)
- CPAS Quarterly Scanner Review



2.3.2.4 Reference Tables

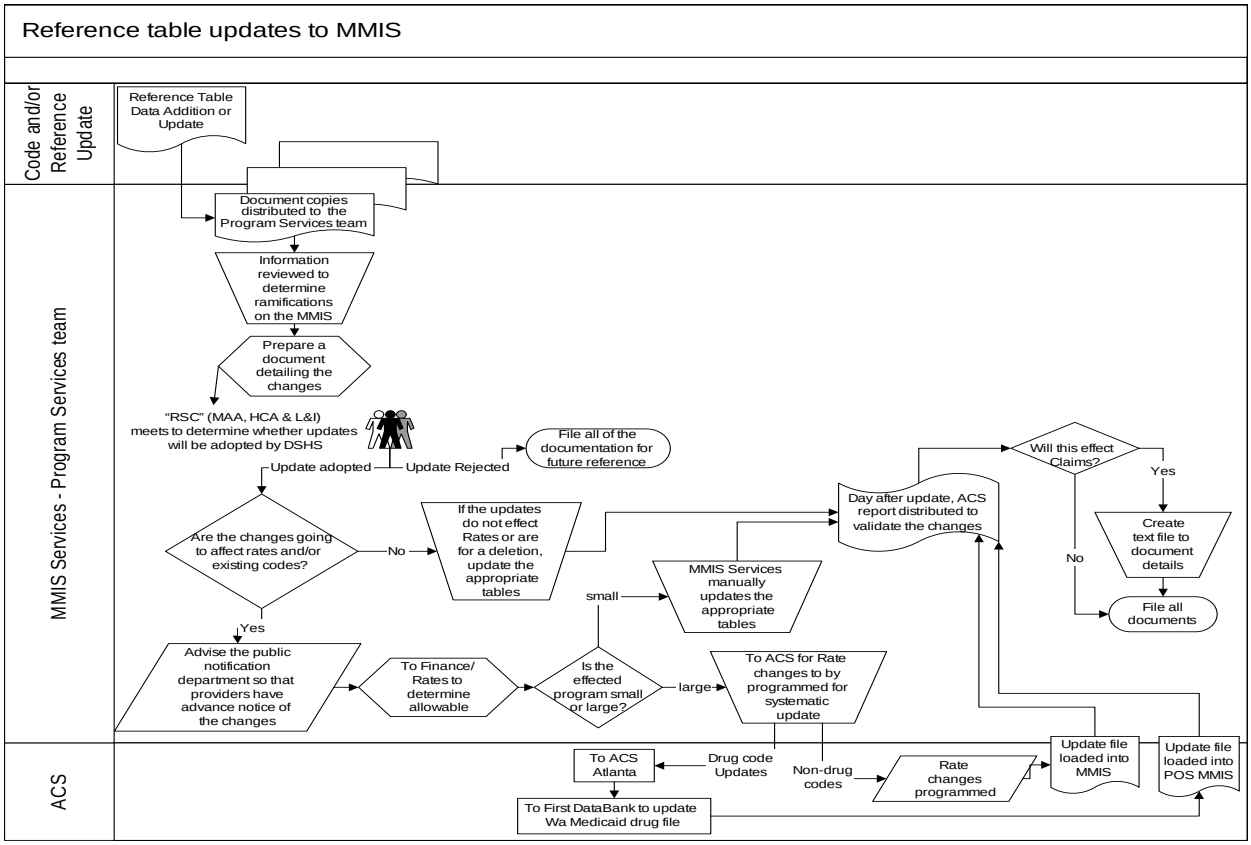
The reference tables in the MMIS are utilized by various Administrations within DSHS and the MMIS Services Staff maintain them. These tables are designed to assist the adjudication of Medicaid claims, and continue to provide coding, edits, text files and rate information. The MMIS Services Staff receive routine and non-routine additions and/or updates to the data stored in the reference tables. An example of a routine reference table update is the annual CPT (Current Procedural Terminology) code updates. The MMIS Services Staff divides the documentation among them, as appropriate.

The MMIS Services Staff review the documentation to determine the ramifications that the new information will have on the MMIS. Once the review is completed, the MMIS Services Staff prepare documentation to be presented to the RSC (committee with representatives from the MAA, HCA (Health Care Authority) and L&I (Labor & Industries)). As the RSC meets and reviews the details, they advise the MMIS Services Staff as to whether the change or addition is accepted or rejected.

If the new codes are accepted, the MMIS Services Staff then determines if and how the change will affect rates and/or existing system codes. MMIS Services Staff communicate this information to the public notification department so that the Medicaid Providers can have an advance notice of the changes. At this point, the MMIS Services Staff route the details to the Rates Section in the MAA Business and Finance Division.

Once the Rates Section has calculated the rates for the addition or update, the documents are routed back to MMIS Services. If the addition or update is small, the MMIS Services Staff manually checks the rates for accuracy and enters the new information directly into the MMIS. If the addition or update is large, the MMIS Services Staff may need to involve ACS to update MMIS electronically. If the Rates Section determines that a MAC price for the Pharmacy Program needs to be updated, added or deleted, the MMIS Services Pharmacy Services Team sends the details to ACS in Atlanta. ACS forwards the request to First DataBank, who holds a contract directly with ACS for maintaining the Washington Medicaid drug file.

The day after MMIS is updated; an ACS report is distributed to the MMIS Services Staff, to validate the changes. At that point, the MMIS Services staff determines which DSHS Departments will be affected by the change. Based on that information, the MMIS Services Staff may create internal notifications and/or text file references into MMIS, so that details of the new information can be distributed. All documentation is filed at the MMIS Services central file location, for future reference.



2.3.2.5 Edits and Audits

When a Medicaid benefit has a limit and/or exclusion, in order to alleviate the need for manual processing and/or ACS intervention, certain limits and contraindicated audits are entered into the system by MMIS Services. These audits are based on criteria that have been previously programmed by ACS. These edits are linked to various claims data and each edit/audit record contains each of the following:

- Parameter number (system generated, 000-999 & 1400-1600)
- Record type
- Brief Description
- Fiscal or Calendar year based
- Limit or contra-indicator
- Audit Criteria Cross Reference, and
- Four lines of text file documentation (adjudication instructions)

When determination has been made to create a limit or exclusion for the MMIS claims, an authorized DSHS representative, such as a Program Manager or Director communicates the request to MMIS Services. The MMIS Services Staff determine how to best implement the request. If a system edit can be created around the previously programmed audit criteria, the MMIS Services Staff enters into the MMIS History Related edits "10" screen. On this screen the MMIS Services Staff enters add, change, delete or inquire and the type of record and/or claim parameters. The next screen available, the Exception Control Screen, allows the MMIS Services Staff to control the claim type and set the disposition of the edit. A claim edits disposition determines whether a message/exception text file displays to the claim examiner upon adjudication. The dispositions available are as follows:

1: super suspend (claim holds until something is changed)

2: auto deny charge without any "pop up" message

3: prompts claims processor to read the "pop up" message

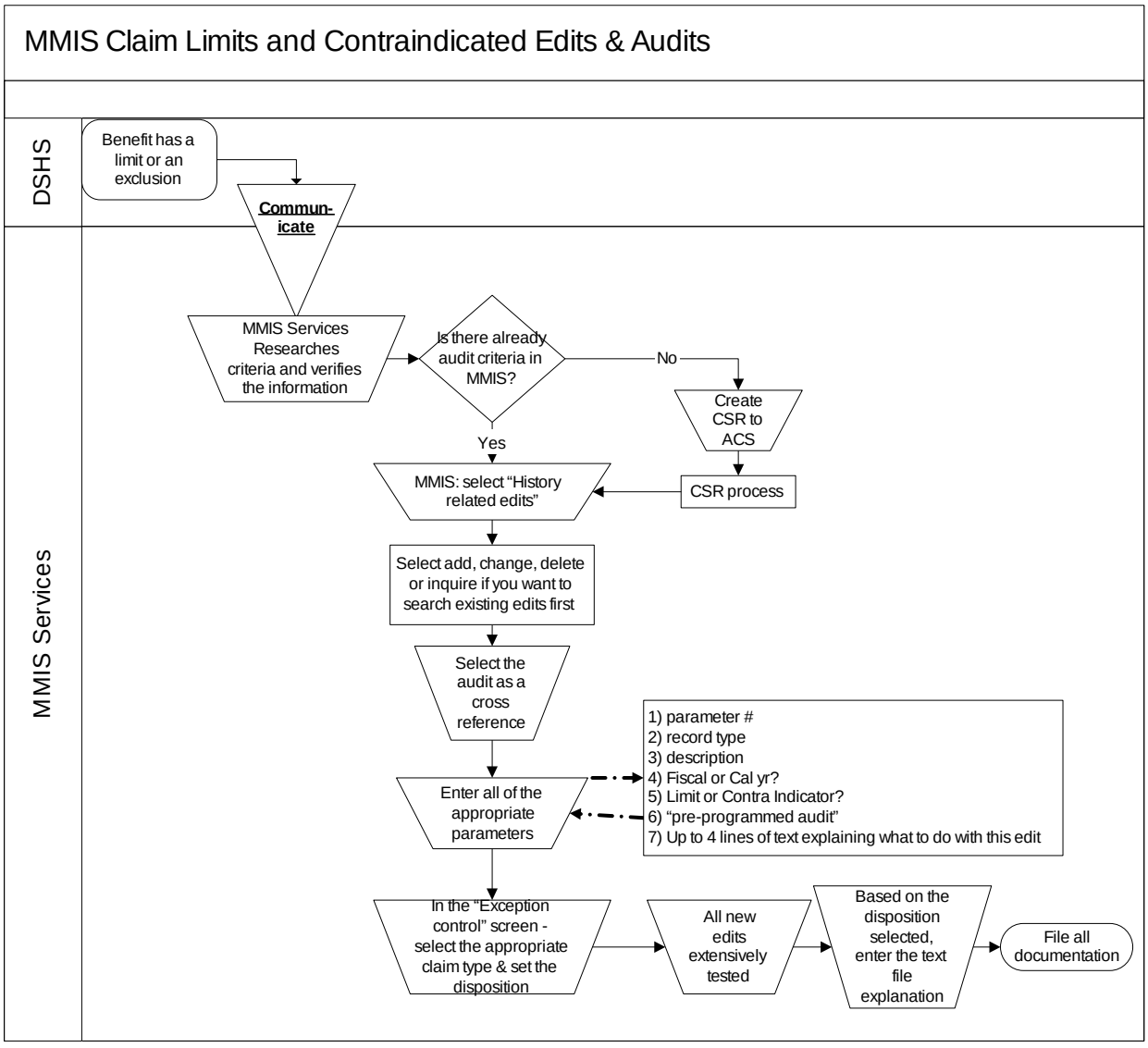
4: pay claim and report to TPL ("pay & chase")

5: pay claim with no pop up

The MMIS Services Staff review the audit criteria currently existing in the MMIS, and determine whether the codes needed for this edit are already referenced or if new audit criteria are required. If new audit criteria need to be programmed, a CSR would need to be created to ACS.

Once the criteria are established, the MMIS Services Staff enter this cross-reference into the control screen. When all of the appropriate details are entered into MMIS for the new limit or

contraindicated audit, the MMIS Services Staff enters a four-line narrative, which will display on the bottom of the claims examiner's screen when one of the audit criteria triggers an exception. In most cases, the four-line narrative does not provide sufficient space to enter text file documentation and/or adjudication instructions for a single edit or audit. If more than four lines are needed for an edit narrative, the MMIS Services Staff develops an exception text file. The text file's claim type indicator and inquiry page number are referenced in the exception line on the bottom of the claims screen, so that the claims examiner knows where to look up this text file detail. When all of the details are completed, the MMIS Services Staff files the documents in the MMIS Services central file location.



2.3.2.6 MMIS Security Requests

The MMIS Security Team is responsible for all MMIS User ID and access privileges and act as a central coordinator and monitor for MAA employees that need access to other State mainframe applications. Each one of the security functions has been delegated to MMIS Services through DSHS Security Manuals and consists of very detailed and complex guidelines. One of the security functions, User ID login security, is administered and maintained by a designated MMIS Services Staff, who maintains a list of all 999 MMIS logins available and a history of assignment for each login. Since the number of login numbers is limited, the numbers are re-assigned once an employee terminates. The Login Excel file is kept on a secured drive, and a master hard copy is kept in a locked drawer in the main cabinet within MMIS Services. The process for a new employee login request varies from that of existing MMIS logins. When an existing employee has not used their login for a period of six months, the system inactivates the login. Other requests for existing MMIS logins are when passwords are forgotten. Because of the difference, the processes are described separately below.

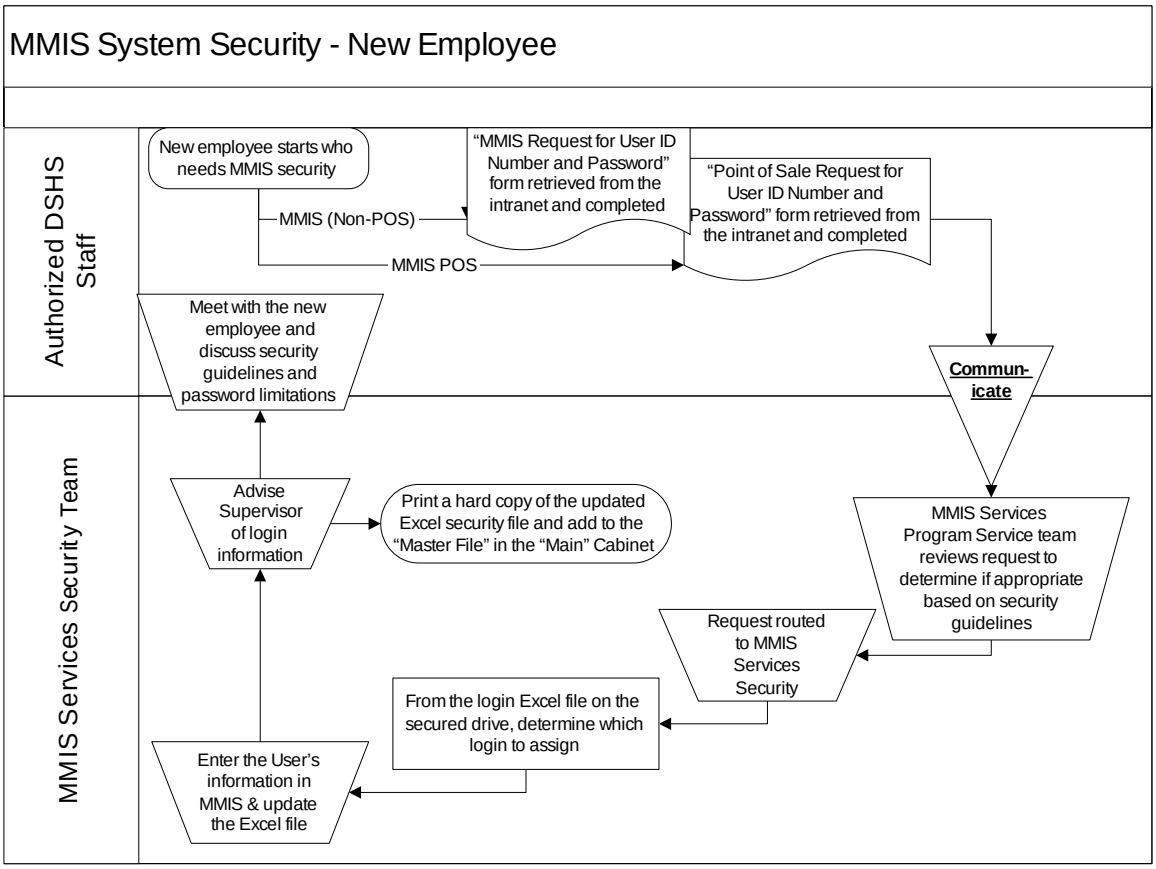
2.3.2.6.1 New Employee Login Request

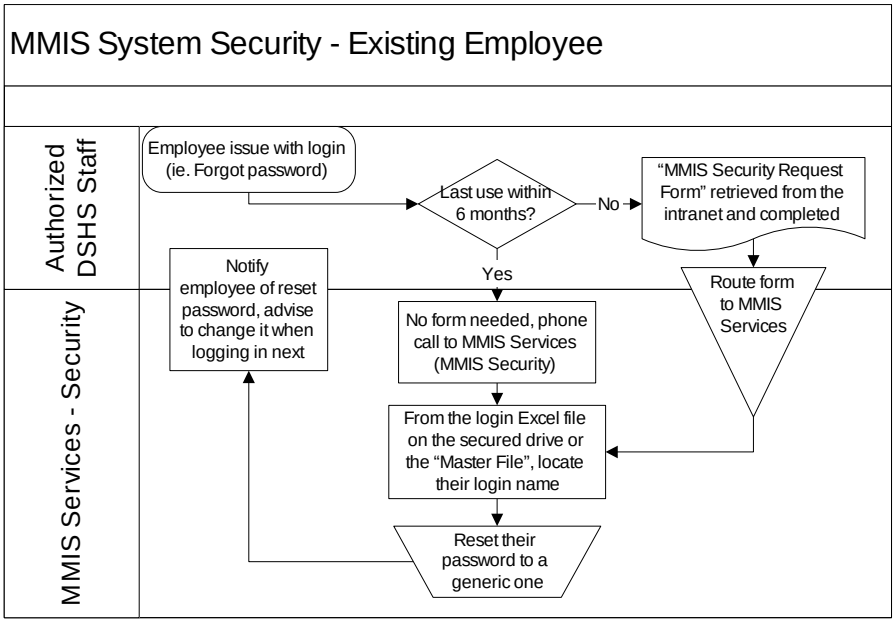
When a new employee needs MMIS access, the supervisor completes the "MMIS Request for User ID Number and Password" or the "Point of Sale (POS) Request for Personal User Number and Password" forms located on the intranet. The supervisor provides the details of the request on the form and forwards the form to MMIS Services. The MMIS Services Team reviews the request to determine if the levels of authorization requested are appropriate, based on established MMIS security guidelines. After approved, the Security Support Staff reviews the Login Excel file to determine which number can be re-assigned to the new user. The Security Support Staff enters the information into MMIS and selects a generic password that will be changed on the first login.

The Security Support Staff contacts the supervisor who requested the new user's security and provides the login information. It is the supervisor's responsibility at that point to provide training on system security and password limitations. The Security Support Staff makes an entry into the Login Excel file with the new user's information and updates the master hard copy.

2.3.2.6.2 Existing MMIS User Security Support

When an existing MMIS user forgets their login and/or password, or if they have caused the system to lock them out after five attempts, the user contacts the Security Support Team. If the user's login has been inactive for six months, the user must complete the "MMIS Security Request Form" and forward it to MMIS Services. Once the designated Security Support Staff receives the request, he references the Login Excel file to obtain the current login information for the user. The Security Support Staff resets the user's password or activates the login and notifies the user.


MMIS System Security - New Employee
Authorized DSHS Staff
MMIS Services Security Team
New employee starts who needs MMIS security
"MMIS Request for User ID Number and Password" form retrieved from the intranet and completed
"Point of Sale Request for User ID Number and Password" form retrieved from the intranet and completed
MMIS (Non-POS)
MMIS POS
Meet with the new employee and discuss security guidelines and password limitations
Commun-icate
Advise Supervisor of login information
Print a hard copy of the updated Excel security file and add to the "Master File" in the "Main" Cabinet
MMIS Services Program Service team reviews request to determine if appropriate based on security guidelines
Request routed to MMIS Services Security
From the login Excel file on the secured drive, determine which login to assign
Enter the User's information in MMIS & update the Excel file


MMIS System Security - Existing Employee
Authorized DSHS Staff
MMIS Services - Security
Employee issue with login (ie. Forgot password)
Last use within 6 months?
No
Yes
"MMIS Security Request Form" retrieved from the intranet and completed
Route form to MMIS Services
Notify employee of reset password, advise to change it when logging in next
No form needed, phone call to MMIS Services (MMIS Security)
From the login Excel file on the secured drive or the "Master File", locate their login name
Reset their password to a generic one

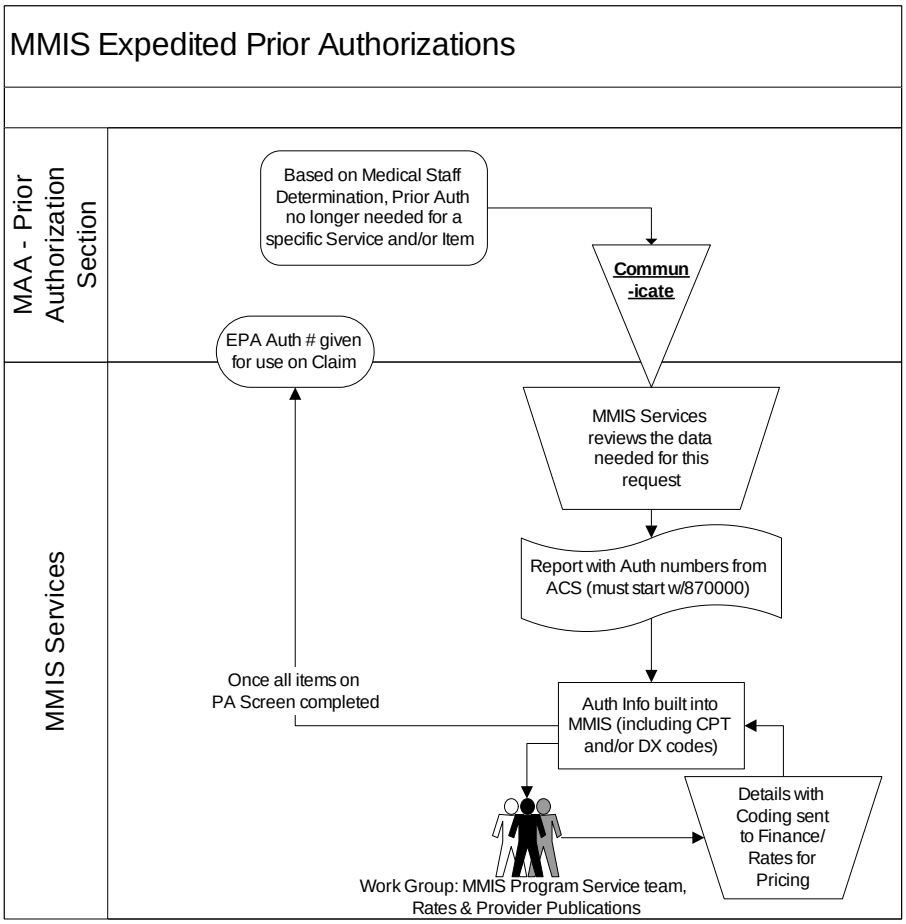
2.3.2.7 Expedited Prior Authorization Set-up

As described in MAA Memo 02-32 titled “Expedited Prior Authorization”, “MAA’s EPA process is designed to eliminate the need for written authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling provider to create an “EPA” number when appropriate.” (1) The set up and maintenance of the expedited prior authorizations in MMIS are coordinated through the MMIS Services Staff.

2.3.2.7.1 MMIS (Non-POS)

The determination to create, change or delete an expedited prior authorization is made by the MAA Administration’s Prior Authorization Section. Once determined, the Prior Authorization Section communicates the details needed and the criteria to MMIS Services Staff. The MMIS Services Staff researches the request to clarify all details and system capabilities. The MMIS Services Staff references the ACS report with the expedited prior authorization numbers available (87000 series) to select the next available number for MMIS entry. The MMIS Services Staff meets with a work group consisting of Program Managers, the Rates Section and Provider Publications to determine the time frame for completion and implementation of the expedited prior authorization. Once all of the details are determined, the MMIS Services Staff enters the information into the authorization screens in MMIS.

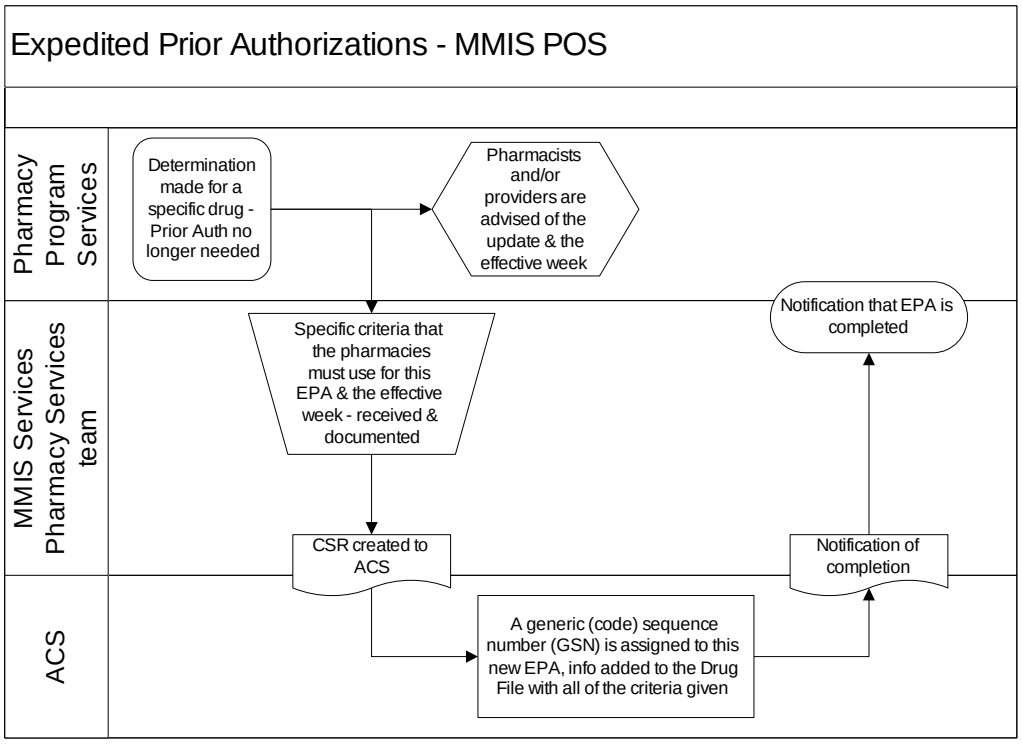
When the expedited prior authorization is completed and active in MMIS, the MMIS Services Staff communicates the number back to the requester and Provider Publications notifies the Medicaid Providers as appropriate.



2.3.2.7.2 POS MMIS

When Pharmacy Program Services has determined that a specific drug can be removed from the prior authorization requirements and placed on an expedited prior authorization (EPA), they send a request to the Pharmacy Services Team within MMIS Services. Pharmacy Program Services requests that Provider Publications educate the Medicaid Pharmacies of the new expedited prior authorizations, the parameters for its usage and the week that the new EPA will be effective. This effective week is approximately thirty days in the future, to provide communication time.

The Pharmacy Services Team within MMIS Services documents the details of the request on a CSR, including the effective week, and route the CSR to ACS. Once ACS receives the CSR, they assign a Generic (code) Sequence Number (GSN) and add the details to the weekly drug file update. Once the Pharmacy Services team receives notification that the new expedited prior authorization is ready for distribution and use, notification is sent back to Pharmacy Program Services.


Expedited Prior Authorizations - MMIS POS
Pharmacy Program Services
MMIS Services Pharmacy Services team
ACS
Determination made for a specific drug - Prior Auth no longer needed
Pharmacists and/or providers are advised of the update & the effective week
Specific criteria that the pharmacies must use for this EPA & the effective week - received & documented
Notification that EPA is completed
CSR created to ACS
Notification of completion
A generic (code) sequence number (GSN) is assigned to this new EPA, info added to the Drug File with all of the criteria given

3. Claims Processing

3.1 Organizational Overview

The Claims Processing Section operates under the MAA's Division of Program Support and consists of staff that is divided into seven primary units, dedicated to the processing of claim payments to Medicaid providers. The Claims Administrative Support Unit consists of two separate teams with document control specialists and OAS (Office Assistant Staff). The two Exam Entry units, Institutional, and Non-Institutional Resolution Units consist of MAS (Medical Assistance Specialist, various levels: MAS1 – MAS5) staff, which is responsible for claim processing and adjustments. The Nursing Home Unit also consists of MAS staff, but specialize in the data entry, processing, and adjustments for nursing home claims only.

The MAA has contracted with Morningside as an external vendor to provide certain administrative and document maintenance functions. Currently, Morningside opens claim mail and scans once the Claims Administrative Unit completes the final sort steps.

3.2 Overview

The Claims Processing Section includes three different business functional areas, New Claims, Adjustments and Nursing Home Claims. At this time, due to system constraints, these functional areas are diverse in their processes. For this reason, the Business Process Reviews have been separated for this document.

3.3 Business Functions

3.3.1 New Claims

When a Medicaid Client receives a service and/or equipment while eligible under a MAA program, the provider is required to submit a detailed itemization to receive payment. These itemization requirements, such as acceptable claim forms, are detailed in the provider billing instructions for each program which are available on the DSHS website.

Providers submit claims using a variety of media types. A claim that is received by mail is considered a 'hard copy' or physical claim, whereas; a claim that is submitted via the Internet or through a clearinghouse, is considered an electronic claim. Claims that are sent electronically have a shorter processing time and systematic processes have replaced many of the manual steps taken with a 'hard copy' claim. Due to this difference that is based on how the claim is submitted, media types are assigned to each claim and are referenced throughout the adjudication process, therefore; the processes are described in this section separately.

The steps that are taken for a new claim's data to be entered into the MMIS vary, dependent on the media type. Once the claim data hits the MMIS Systematic Adjudication and Edit Cycle, the process is standard, but electronic media type claims are considered priority.

Claims that cannot be completely adjudicated are placed in a suspended status. Once the issue has been resolved it is sent back through the MMIS Adjudication and Edit Cycle and has priority over newer claims.

3.3.1.1 New Paper Claims

Hard copy claims received by mail are scanned, entered into MMIS and sent for destruction. These hard copy claims may be in the form of a HCFA 1500, UB or Dental/ADA claim form, specifically dependent on the services provided. Morningside receives and opens the mail, based on a contract with DSHS for certain clerical and scanning responsibilities.

3.3.1.1.1 Claim Input

When hard copy claims are received, Morningside opens the mail and sorts them by claim form type, such as medical versus dental. These opened and sorted documents are delivered to the Claims Administrative Support Unit. This unit continues the sorting process by separating according to the claim type and for the HCFA 1500 forms only, OCR (Optical Character Recognition) worthiness. If a red HCFA 1500 claim form is submitted and typed in black ink, there is a high percentage chance that the data on that claim form can be read by the OCR software and systematically uploaded into MMIS. For this reason, claims that are not OCR worthy need to be separated and sent through a different claim entry process. After this sorting procedure, the claims are given back to Morningside so that they can batch, count and scan the claims. As each claim is scanned, an ICN number is systematically assigned to the image. Morningside sends the claim images that are OCR worthy through the OCR software that pulls information from the imaged format to a data up loadable format. At this point, Morningside transfers the OCR claim data back to the Claims Administrative Support Unit and shreds the paper.

The Claims Administrative Support Unit reviews the OCR documents through an "IKE" (Intelligent Keyed Entry) process, for data transfer accuracy. For HCFA 1500 claims that went through the OCR software and the data was transferred correctly, the Claims Administrative Support Unit moves the claims into the MMIS adjudication and edits process. For all other claims, the Claims Administrative Support Unit extracts the data and routes the images to the Exam Entry Unit for review.

The Exam Entry Unit MAS staff utilizes SSV (Split Screen Verification), which is a claim image viewing technique that allows them to view the image and the MMIS claim screen at the same time. The MAS "cleans" the claim so that correct information is saved in MMIS. Once the data is correct in MMIS, the MAS routes the claim into the MMIS Adjudication and Edit process.

For claims that are non-OCR worthy, the paper claim is routed to the MAS staff in the Exam Entry Unit to be manually entered into MMIS. Once the MAS accepts the data, it is systematically sent to the MMIS Adjudication and Edit process. After the manual entry from paper, claims are sent back to Morningside to be shredded.

3.3.1.1.2 Claim Adjudication

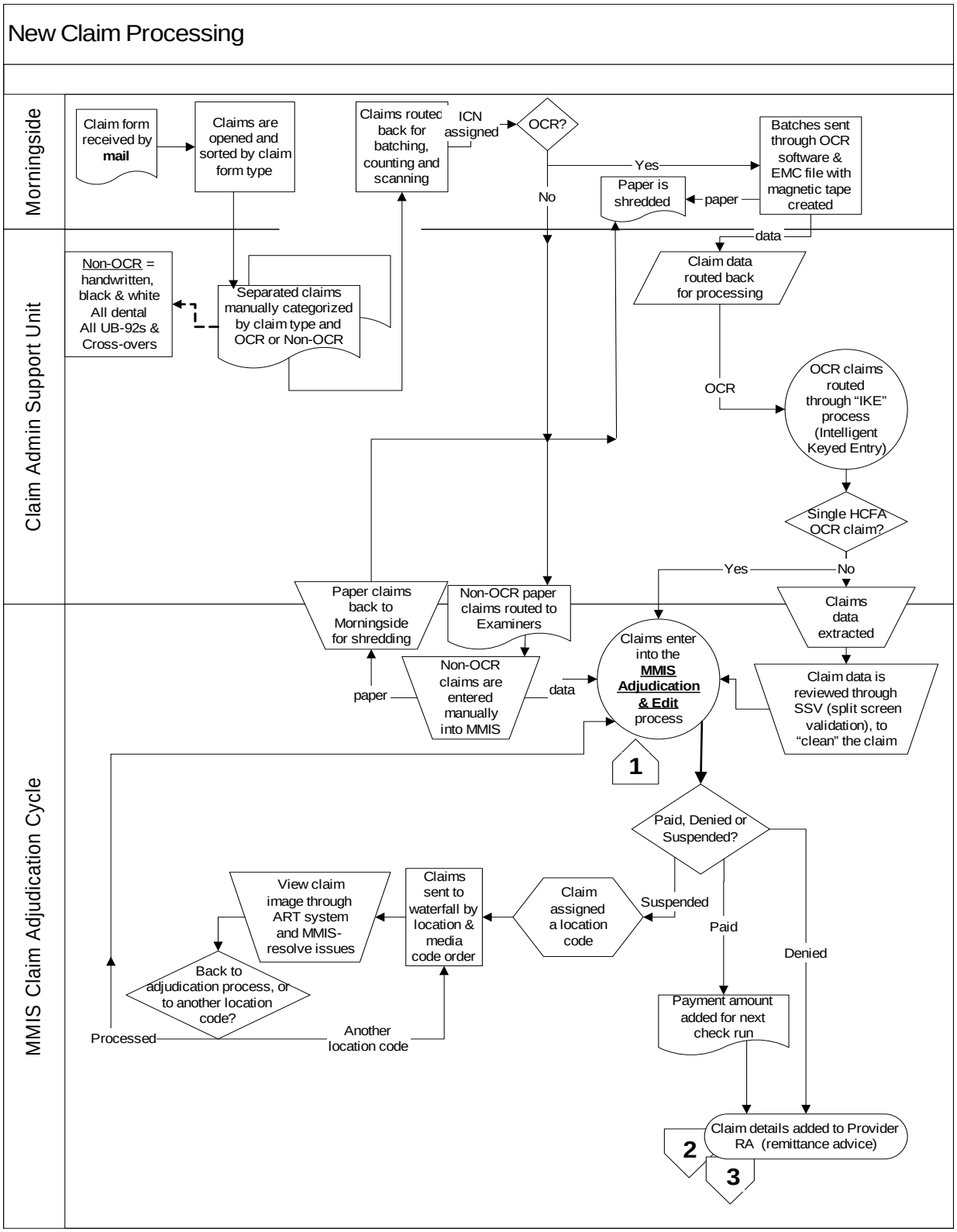
The MMIS Adjudication and Edit process systematically determines whether a claim can be paid, denied or suspended for further review. If the claim can be paid, it is added to the payment amount on the provider's next check and the details are added to the provider's remittance advice (RA). If the claim is denied, the system adds the details to the provider's remittance advice (RA).

If the claim is suspended for further review, the system assigns an exception code that is based on criteria programmed into the MMIS. These exception codes correspond to location codes that are used in MMIS to prioritize all of the claims into a "waterfall" process to be worked by MAS staff. The MAS retrieves claims from the waterfall and utilizes SSV (Split Screen Verification) to view the image of the claim, along with instructions documented in the text files to resolve the issues that are suspending the claim in MMIS. Once the issues for that location code are resolved, the MAS determines whether the claim can be sent back through the MMIS Adjudication and Edit process or whether to assign a new location code in the waterfall. Any claims that were previously suspended by MMIS are assigned as a priority when they are routed back to the original Examiner who entered the claim, in "adjudication" mode.

3.3.1.2 New Electronic Claims

The Claims Processing Section allows Medicaid providers to submit claims for payment through the mail or electronically. When a provider chooses to submit claims electronically, versus by mail, there are many options that may be taken. Since the current MMIS can only accept data in a specific format, MAA provides dual support processes, in order to maintain compliance with HIPAA guidelines. The MAA has contracted with ACS to provide an EDI Gateway as a clearinghouse for acceptance, translation of electronic claim files and provider remittance advice (RAs) as well as provide support for direct entry through an EDI Gateway.

The electronic claim submission processes for providers vary dependent on the technology and software utilized, therefore; each process has been described below separately.


New Claim Processing
Morningside
Claim Admin Support Unit
MMIS Claim Adjudication Cycle
Claim form received by mail
Claims are opened and sorted by claim form type
Claims routed back for batching, counting and scanning
ICN assigned
OCR?
Yes
No
Batches sent through OCR software & EMC file with magnetic tape created
Paper is shredded
paper
data
Non-OCR = handwritten, black & white All dental All UB-92s & Cross-overs
Separated claims manually categorized by claim type and OCR or Non-OCR
Claim data routed back for processing
OCR
OCR claims routed through "IKE" process (Intelligent Keyed Entry)
Single HCFA OCR claim?
Yes
No
Paper claims back to Morningside for shredding
Non-OCR paper claims routed to Examiners
Claims data extracted
Claims enter into the MMIS Adjudication & Edit process
paper
Non-OCR claims are entered manually into MMIS
data
Claim data is reviewed through SSV (split screen validation), to "clean" the claim
1
Paid, Denied or Suspended?
Suspended
Paid
Denied
Claim assigned a location code
Claims sent to waterfall by location & media code order
View claim image through ART system and MMIS- resolve issues
Back to adjudication process, or to another location code?
Processed
Another location code
Payment amount added for next check run
Claim details added to Provider RA (remittance advice)
2
3

The following breakdowns describe the process that a claim follows for each electronic option:

1. If the provider contracts with a clearinghouse, there may also be further options to either submit the hard copy claim for the clearinghouse to data enter or to accept claim data that is transmitted through non-HIPAA compliant software. The clearinghouse acts as an agent for the provider to transmit claims data to be processed through the ACS EDI Gateway (Medicaid's clearinghouse). The clearinghouse converts the claim data into an X12 837 file and submits the file to ACS. The ACS EDI Gateway first determines whether the data is acceptable or whether it should be rejected back to the submitter. If the data is acceptable, the EDI Gateway runs the file through a translator system that prepares the data to be received by the MMIS, in an 837 IRL File.

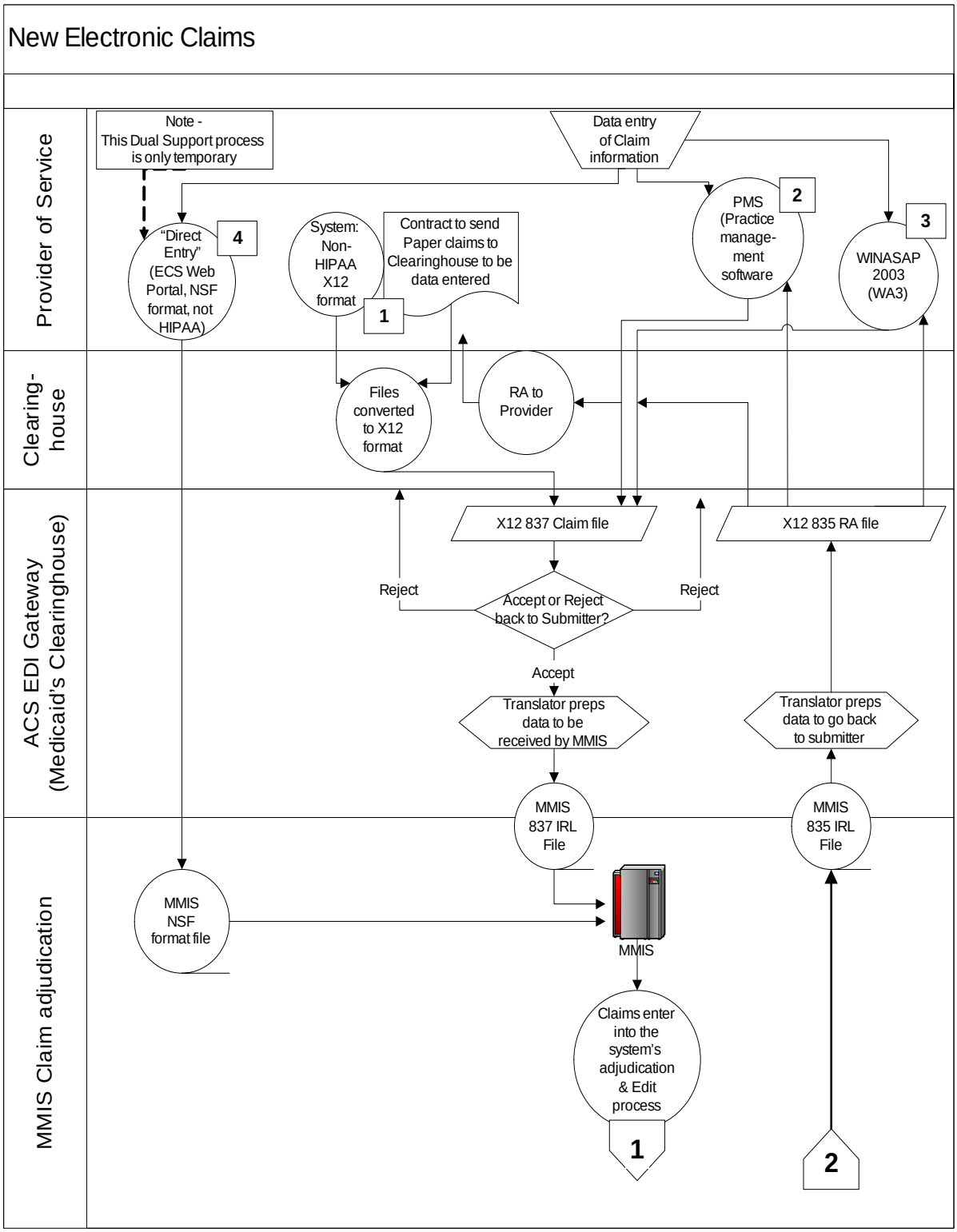
2. If a provider purchases a PMS (Practice Management Software) that is HIPAA compliant, claim data can be sent directly to the ACS EDI Gateway. The provider signs an agreement with ACS to utilize the EDI Gateway through the Internet. The provider enters the information through the PMS and the ACS EDI Gateway determines whether the data is acceptable or whether it should be rejected back to the provider. If the data is acceptable, the EDI Gateway runs the file through a translator system that prepares the data to be received by the MMIS, in an 837 IRL File.

3. ACS offers a data entry tool through the Internet called WINASAP. A provider contracts directly with ACS for this service. If the provider utilizes this tool for submitting claims, they can also receive their remittance advice electronically, X12 835 format. The provider enters the information through WINASAP and the ACS EDI Gateway determines whether the data is acceptable or whether it should be rejected back to the provider. If the data is acceptable, the EDI Gateway runs the file through a translator system that prepares the data to be received by the MMIS, in an 837 IRL File.

4. Since a good portion of Washington's provider network are not yet HIPAA compliant, as well as the current MMIS, the claims processing unit also allows providers submit claims using "Direct Entry" through an Electronic Claims Submission (ECS) Web Portal. By using this Web Portal, the file is generated directly into MMIS in NSF format that is not HIPAA compliant. This process is only temporary while MAA's "Dual Support" policy is in effect.

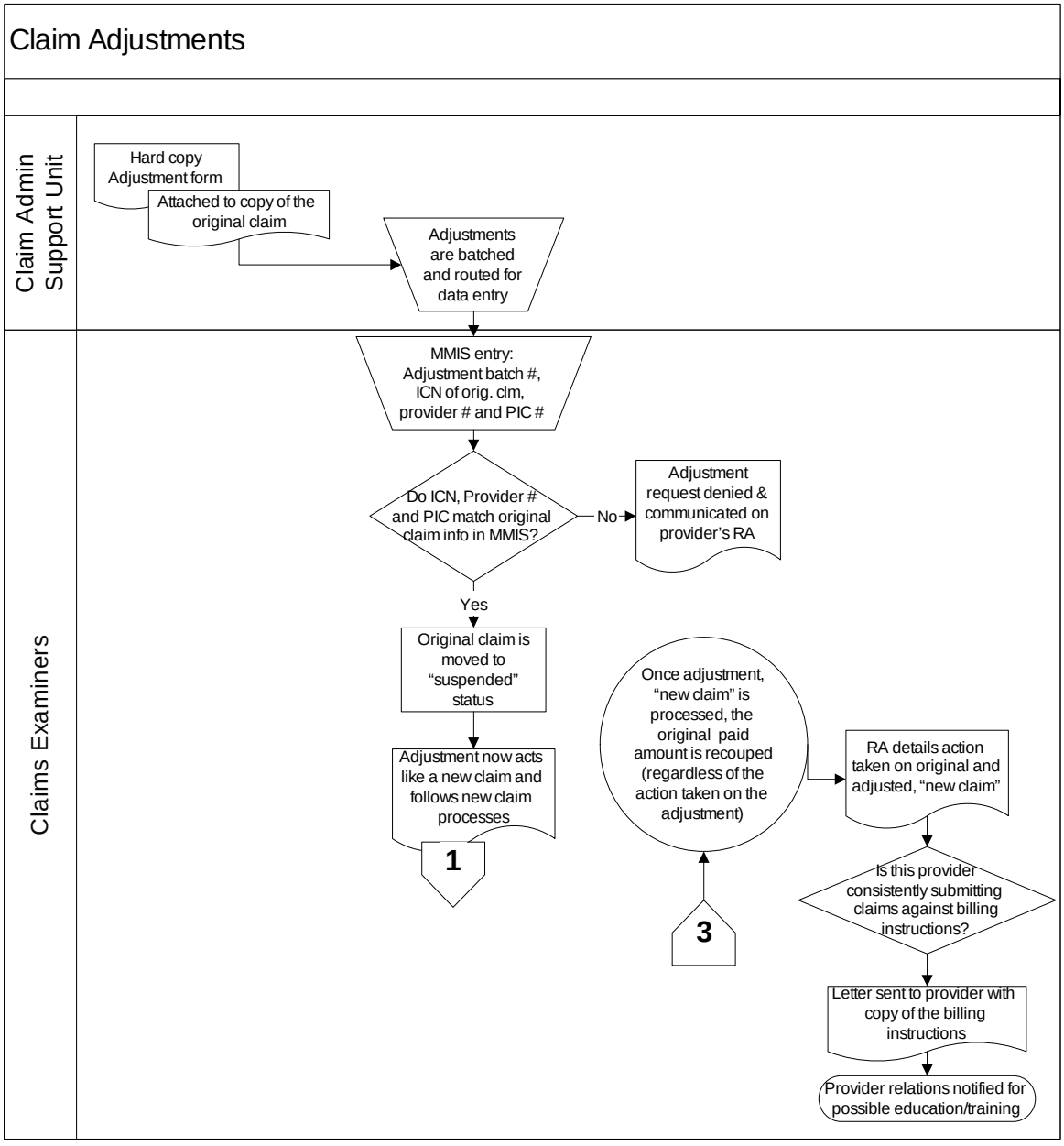
Once the claim data is received and loaded into MMIS, the claims enter the MMIS Adjudication and Edit process, as described in the above sub-section for Claim Adjudication.

Once the claim is completely processed through MMIS and a provider remittance advice (RA) is generated, for those provider claims that were submitted through the ACS EDI Gateway, an 835 IRL file is sent from MMIS back to the Gateway. This 835 IRL file is sent through the translator system that converts the file to a HIPAA compliant X12 835 RA file. At that point, the RA file is transmitted back to the original submitter.


New Electronic Claims
Provider of Service
Clearing-house
ACS EDI Gateway (Medicaid's Clearinghouse)
MMIS Claim adjudication
Note - This Dual Support process is only temporary
Data entry of Claim information
"Direct Entry" (ECS Web Portal, NSF format, not HIPAA)
4
System: Non-HIPAA X12 format
1
Contract to send Paper claims to Clearinghouse to be data entered
PMS (Practice manage-ment software
2
WINASAP 2003 (WA3)
3
Files converted to X12 format
RA to Provider
X12 837 Claim file
X12 835 RA file
Reject
Accept or Reject back to Submitter?
Reject
Accept
Translator preps data to be received by MMIS
Translator preps data to go back to submitter
MMIS 837 IRL File
MMIS 835 IRL File
MMIS NSF format file
MMIS
Claims enter into the system's adjudication & Edit process
1
2

3.3.2 Adjustments

When a provider feels that a claim has been processed incorrectly, the program's billing instructions give specific details to the provider on how to submit the information to MAA. When a claim requires adjustment, the original claim details along with a paper adjustment form must be submitted to the Claims Processing Unit.



The Claims Processing Unit receives adjustment requests daily, and the Claims Administrative Support unit batches them by date and routes them to the MAS to be entered into MMIS. The

MAS enters the adjustment batch number, ICN of the original claim, the provider number, and the Client's PIC number into MMIS. The MAS reviews the information on the adjustment form to verify that everything matches the original claim. If the information does not match the original claim, the adjustment request is denied and communicated back to the provider on the remittance advice. If the information matches, the MAS changes the original claim to a "suspended" status. At this point, the adjustment takes the form of a new claim and the MAS follows the Claim Adjudication steps as detailed above.

Once the adjusted new claim is processed, the MAS retrieves the original claim and requests any paid amount back from the payee, regardless of the action taken on the adjustment. The provider's remittance advice details the actions taken on both of these claims and if the MAS determines that the provider is consistently submitting claims against the guidelines in the billing instructions, a letter is attached to the RA. This letter explains how to retrieve the billing instructions from the MAA website and the MAS forwards a copy of the letter to the Provider Relations Section for possible education or training.

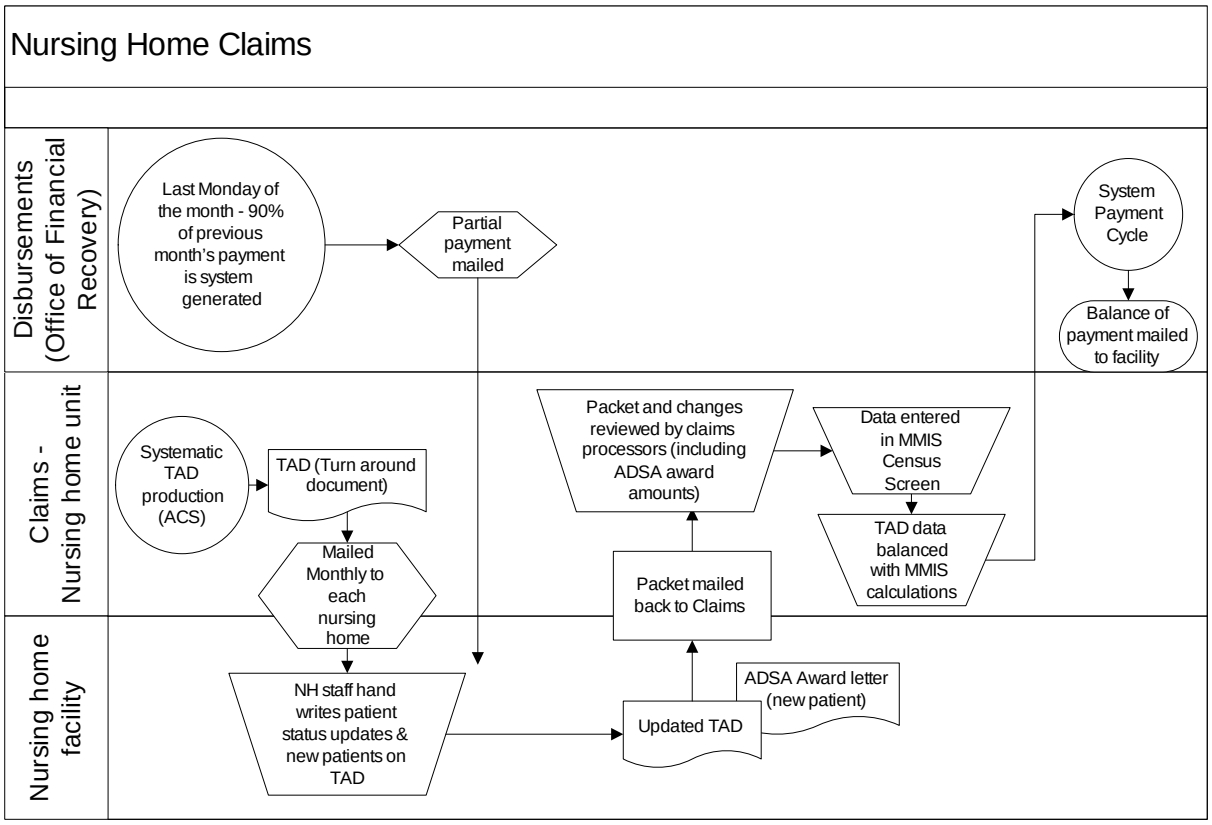
3.3.3 Nursing Home Claims

Under the DSHS Aging and Disability Services Administration (ADSA) as well as the Division of Developmental Disabilities Program, Nursing Facilities or home and community based services are covered for qualified Clients. These qualified Clients receive an award letter from the DSHS Program that is presented to the facility upon admission. This award letter is used to determine the cost share percentage for the Client and the Medicaid Program. The current process for administering the coverage for nursing home facilities is coordinated through a TAD (Turn Around Document) that is routed back and forth between the facility and the Nursing Home Unit of Claims Processing. Projects are currently underway to revise this process, however; the process flow remains the same to date.

On the last Monday of each month two MMIS systematic process generate a TAD and a payment to the nursing facilities that are providing care to qualified Clients. The payment is 90% of the previous month's total payment. Each TAD lists the Clients that were residents during the previous month and provides fields for the nursing home to add new residents and/or make changes. The Finance Section mails the facility payments and the TADs are mailed by the Nursing Home Unit.

Once the facility receives the TAD, it is their responsibility to review and make corrections and/or additions as appropriate. When the form is complete, the nursing facility mails the updated TAD and any award letters for newly placed Clients back to Claims Processing.

As the Nursing Home Unit receives the TADs and award letters, they review the documents for accuracy and the MAS enters the data into the MMIS census screen. Once all of the changed and new information is entered, the MAS balances the TAD to the calculations made by MMIS. If the TAD balances, the remaining amount of the nursing home's payment is processed on the next MMIS payment cycle. The Finance Section mails the additional payments after each payment cycle check process.


Nursing Home Claims
Disbursements (Office of Financial Recovery)
Claims - Nursing home unit
Nursing home facility
Last Monday of the month - 90% of previous month's payment is system generated
Partial payment mailed
System Payment Cycle
Balance of payment mailed to facility
Systematic TAD production (ACS)
TAD (Turn around document)
Mailed Monthly to each nursing home
NH staff hand writes patient status updates & new patients on TAD
Packet and changes reviewed by claims processors (including ADSA award amounts)
Data entered in MMIS Census Screen
TAD data balanced with MMIS calculations
Packet mailed back to Claims
ADSA Award letter (new patient)
Updated TAD

4. Prior Authorization

4.1 Organizational Overview

The Washington Administrative Code (WAC) mandates Medicaid Client eligibility and benefits, and in order to administer medically necessary benefits, the Division of Medical Management has established operational areas that prior authorize services and equipment.

4.2 Overview

Prior Authorization is an approval for certain medical or dental services, equipment or supplies and prescription drugs. Prior authorization is obtained before specified services are provided to a Medicaid Client, and acts as a precondition for the provider of service's reimbursement. Each MAA Program provides specific billing instructions that detail the services that require prior authorization and the steps a provider must take to obtain the authorization. As part of the DSHS core provider agreement, a provider of service is required to utilize the billing instructions, which are available online, to determine when a service, equipment or supply needs to be prior authorized.

Since the scope of Prior Authorization includes a wide variety of services, equipment, supplies and prescription drugs, the functional areas are divided out by type of authorization. One standard between departments are the types of staff. Each functional area consists of a supervisor, OAS (Office Assistant Staff), and varied levels of MAS (Medical Assistance Specialist) Staff. Even though they all reference the MMIS, they each have their own unique work processes. Therefore, each functional business area's processes are detailed below.

4.3 Business Functions

4.3.1 Clinical Prior Authorizations

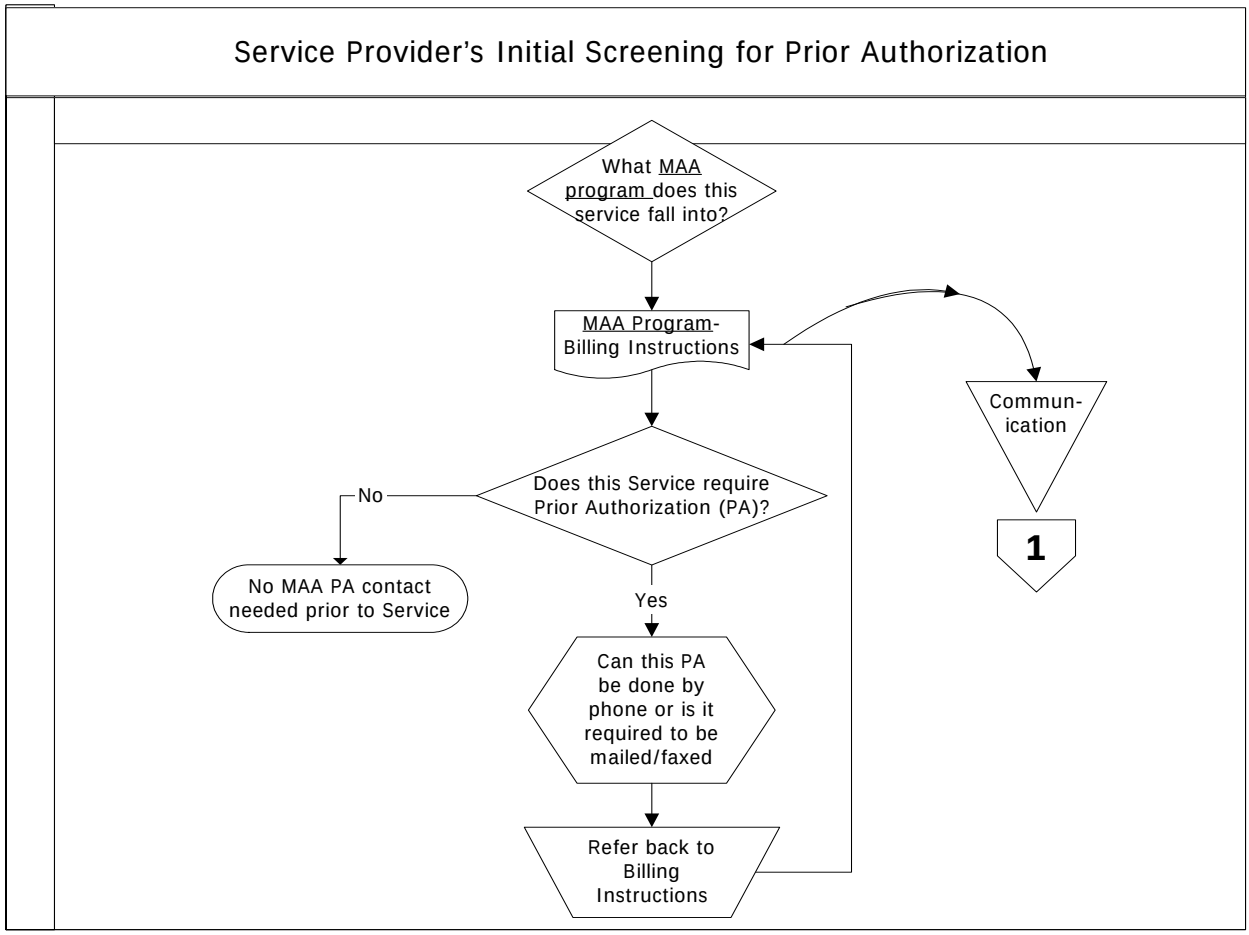
The Prior Authorization processes for clinical services are initiated by the provider of service and are based upon the guidelines set in the MAA Program's billing instructions. The functional areas that perform these prior authorization processes are ETR (Exception to the Rule), LE (Limitation Extension), L-TAC (Long Term Acute Care), and PM&R (Physical Medicine and Rehabilitation). The provider of service is responsible for obtaining the appropriate authorizations prior to the service being rendered to the Medicaid Client; therefore, a prior authorization process needs to be followed for each individual service.

Once the Provider has communicated the authorization request, the MAS staff begin the intake process, to insure that the clinical staff review only appropriate requests that have all of the required information attached. Even though all of the Prior Authorization staff can perform the

intake process, dependent on staff availability, the clinical staff reviews the details of the request and the medical information to make the authorization decision.

4.3.1.1 Provider's Initial Screening

Prior to rendering services to a Medicaid Client, the provider is required to refer to the Medicaid Program's billing instructions. The provider uses these instructions to determine if the service requires prior authorization. If required, the provider utilizes the billing instructions detailing how to initiate the process and communicates the request to the MAA Program's prior authorization department.



4.3.1.2 Prior Authorization Intake Process

The prior authorization unit receives requests throughout the day. The OAS or MAS attaches an intake sheet to each request that is used throughout the process to record important information about the Client, the provider and/or facility, and the services being requested. This intake sheet is also utilized to store hand written clinical review information and

justification for the final authorization determination, such as WAC (Washington Administrative Code) references. The MAS accesses MMIS Client screens and reviews standard eligibility questions:

Is the Client eligible for services and on an eligible program for the scope of services?

NO: The MAS faxes the information back to the provider and no further documentation is processed.

YES: Does the Client have Medicare or a managed care program?

NO: The MAS checks MMIS, WAC (Washington Administrative Code) and the Billing Instructions to see if the service requested requires PA.

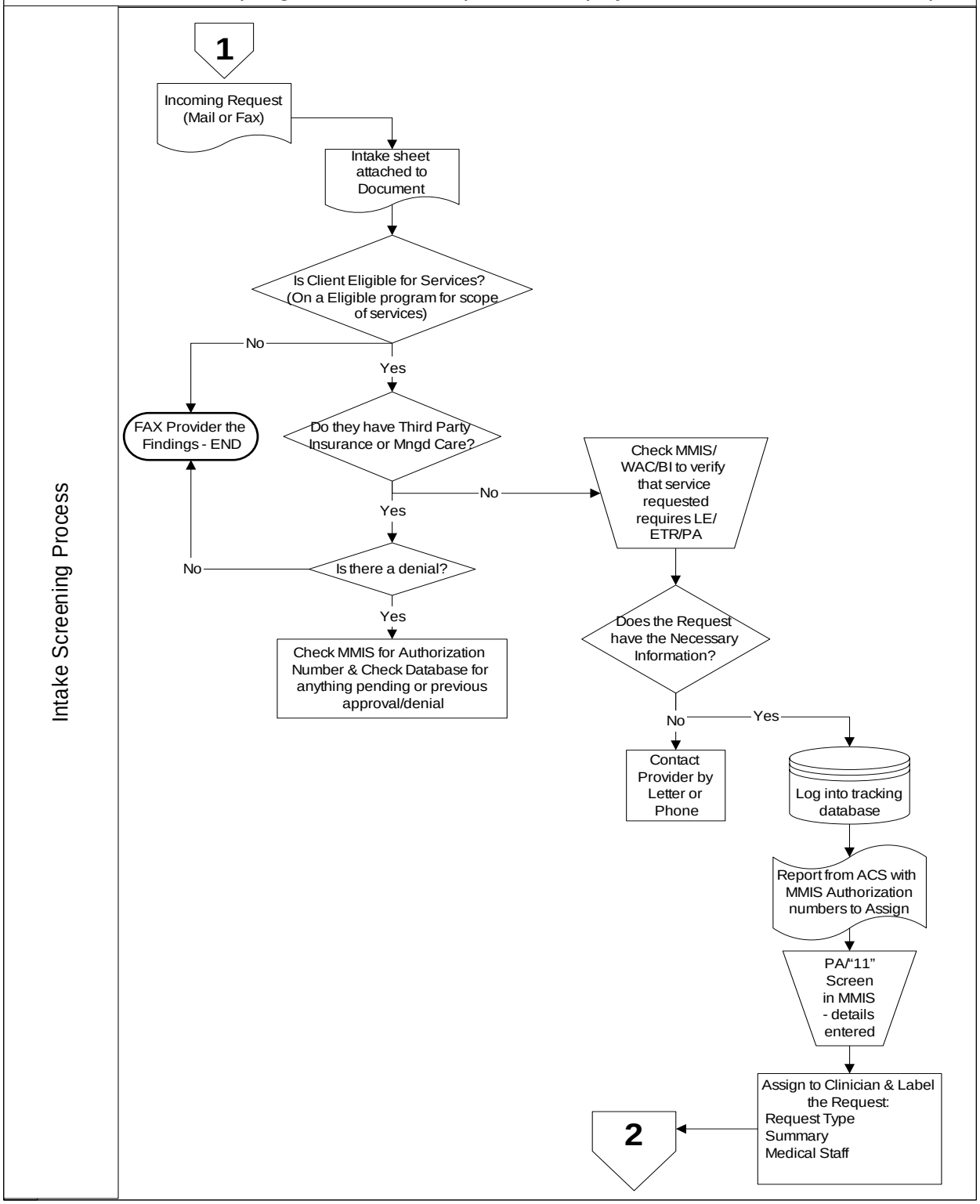
YES: Has Medicare or a managed care program previously denied the service?

NO: The MAS faxes the information back to the provider and no further documentation is processed.

YES: The MAS checks MMIS for existing authorizations and checks the tracking database for anything pending, previously denied or approved.

At this point, the MAS verifies that all of the necessary documentation is attached, to prove medical necessity. If the documentation provided is not complete, the MAS makes a phone call or generates a letter to the provider advising of the information needed to complete the review. If all of the information is received, the MAS makes an entry into the request-tracking database. The MAS then refers to the green bar report generated by ACS with all of the authorization numbers open for use, to select a MMIS authorization number. From the MMIS main menu, the MAS selects the Prior Authorization, option 11. From here, the MAS enters the authorization number and the Client's PIC number to get to the authorization details screen. The MAS presses enter for the detail screen and completes the entry of the request details. The MAS assigns the request to a Clinician and labels the physical documents. The MAS sorts with the other requests, by request type.

Clinical Prior Authorization - **ETR** (Exception to the Rule), **LE** (Limitation Extension), **L-TAC** (Long Term Acute Care) & **PM&R** (Physical Medicine & Rehabilitation)



4.3.1.3 Prior Authorization Decision Making

Upon receipt of request documents, the Clinician begins the decision making process with a series of standard questions:

Does the requested service meet the WAC guidelines and Medical Necessity?

NO: The Clinician writes the determination details on the intake sheet and routes the file back to the MAS. The MAS enters the determination information into the tracking database, the denial database and the MMIS authorization. The MAS creates a denial letter and routes the letter to the physician on staff for a signature. Once the letter is signed, the OAS or MAS mails a copy to the Client and the original to the provider.

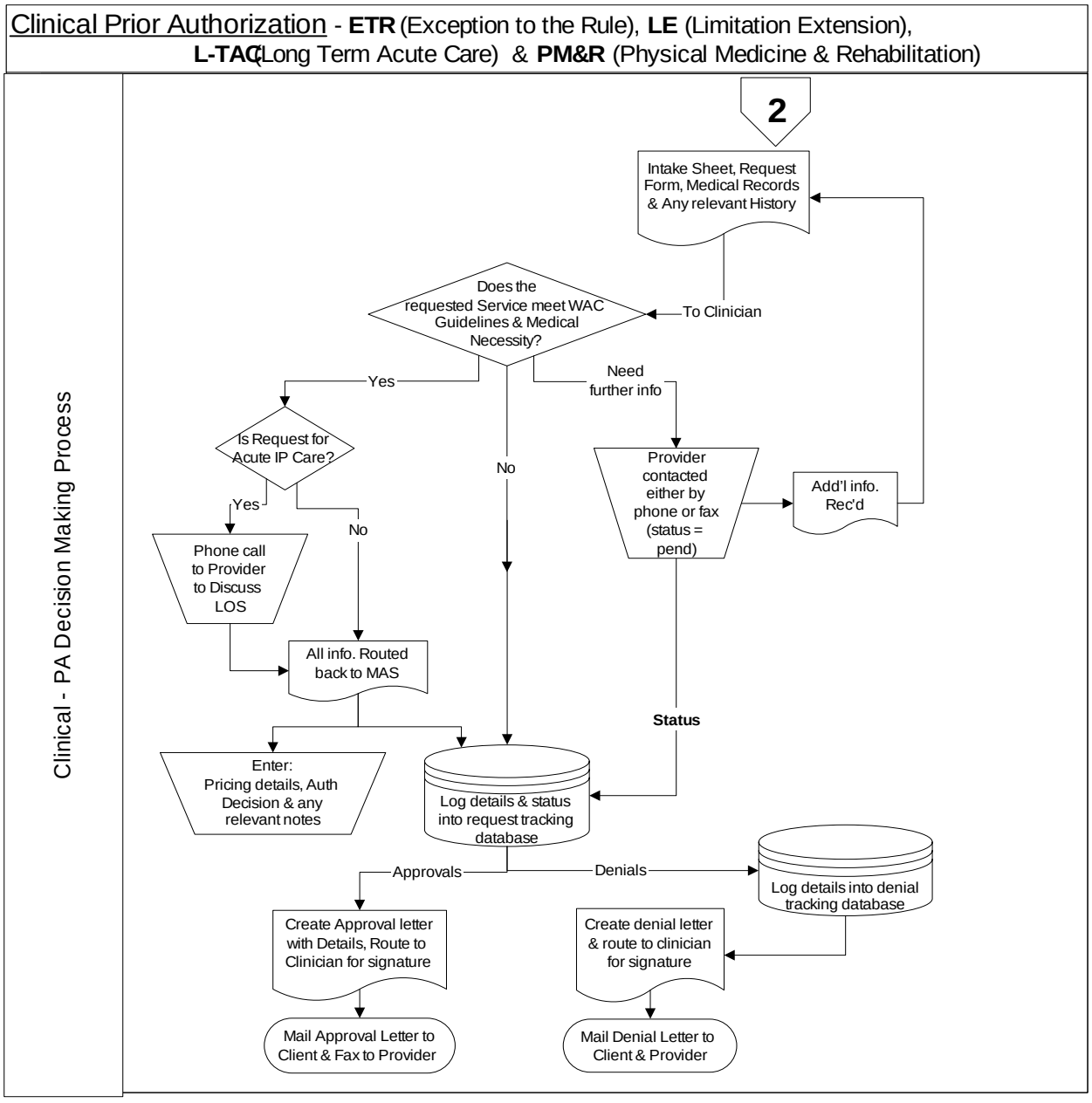
NEED FURTHER INFO FROM PROVIDER: The Clinician contacts the Provider by phone or fax to communicate the information needed. The Clinician routes the request back to the MAS, to update the tracking database and MMIS. Once the needed information is received, the MAS attaches the new documents to the existing file and sends them back through the decision making process.

YES: Is the request for Acute Inpatient Care?

YES: The Clinician telephones the provider to discuss a length of stay (LOS). Once the Clinician and the provider have determined the LOS, the Clinician routes all of the documents back to the MAS. The MAS updates MMIS with the pricing details, authorization decision and any relevant notes that the Clinician has written on the intake sheet. The MAS then updates the tracking database.

NO: Continue with the PA Decision Making Process.

Once the Clinician has made an authorization decision, she documents all of the details on the intake sheet and routes the file back to the MAS. The MAS updates MMIS, the tracking database, and the denial database if denied. The OAS or MAS generates a decision letter from the letter database. The OAS or MAS utilizes key fields from the database to trigger a decision letter. Whether the request is approved or denied, prior to the letter being mailed out, the OAS or MAS routes the letter to the physician on staff for a signature. The OAS or MAS mails a copy of the letter to the Client and the original to the provider.



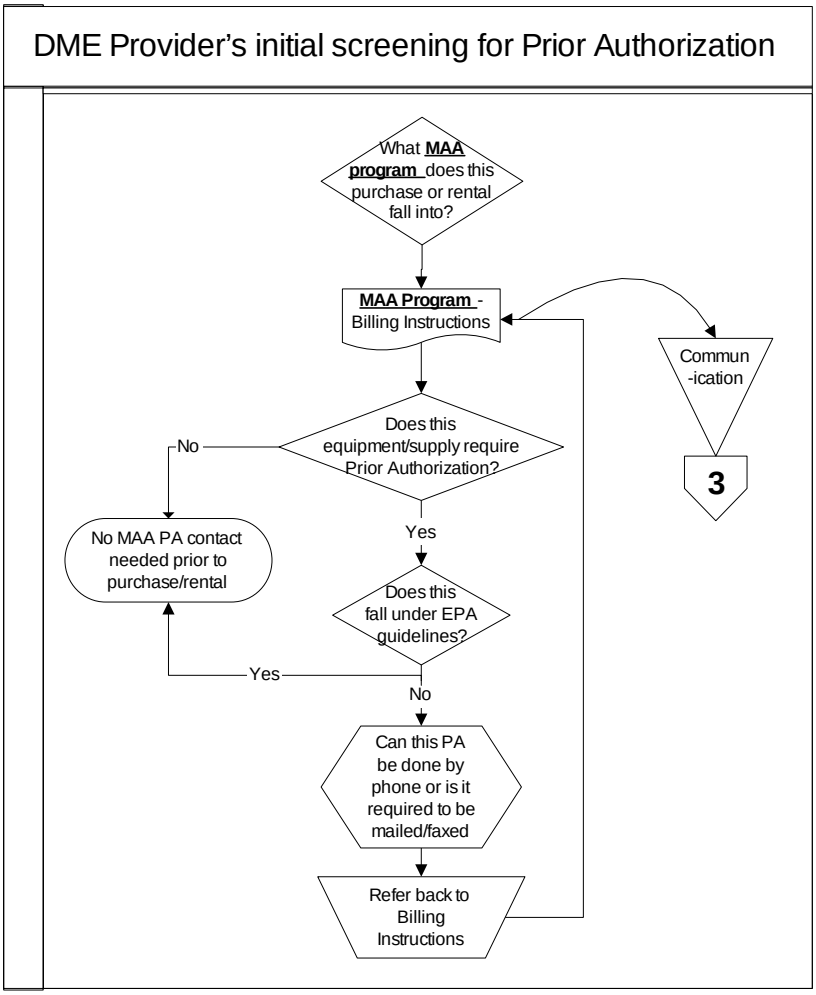
4.3.2 DME (Durable Medical Equipment)

The DME Prior Authorization staff takes incoming telephone calls and receives mailed requests for the authorization of equipment and/or supplies. The Billing Instructions detail when an authorization request can be made by telephone and these requests are typically for simple requests or repairs to existing equipment. For each request received by mail, the unit stores the original documents in folders, sorted by the Client's name, in a master file room. These

files are utilized for historical reference on future requests and for the event of a fair hearing request on a denial.

4.3.2.1 DME Provider's Initial Screening Process

Prior to providing a purchase or rental to a Medicaid Client, the provider or supplier is required to refer to the Medicaid Program's billing instructions. The provider or supplier uses these instructions to determine if the service requires prior authorization. If required, the provider or supplier utilizes the billing instructions detailing how to initiate the process and communicate the request to the MAA Program's prior authorization department.



4.3.2.2 DME Prior Authorization Intake Process

Authorization requirements and communication methods are detailed in the Billing Instructions and the determining factor is the type of equipment or supply requested. The DME Prior Authorization Staff receive both telephonic and mail requests. As telephonic requests are received, the MAS3 keeps track of volume on the "Monthly Telephone Log Sheet". The MAS3 usually makes a decision during the same call and bypass some of the steps taken for mail requests, dependent upon the complexity.

As mail is received, the OAS opens, sorts, and date stamps each piece. The Unit Supervisor or other designated person performs a preliminary review for each request. This review is performed to pull out requests that do not contain required information such as serial number, physician prescription or for a service that does not require prior authorization. For these incomplete requests, the Unit's MAS2 completes and attaches a form to each request pulled out, and faxes it back to the requester. The Unit Supervisor then counts the remaining requests on the "Daily Hard Copy Requests Received" form and assigns an MAS3, dependent on workload. Once the assignment is made, the documents are routed to the OAS.

The OAS searches the master file room to see if there is an existing file folder for previously received requests on this Client. For those Client files that are pulled from the master file room, the OAS completes an "out-card" prior to removal. If there is not already a file folder, the OAS creates a new one. The OAS attaches an intake sheet to the folder and routes to the MAS staff. The MAS reviews the request and MMIS history to document any other equipment and/or supplies on the intake sheet, with the corresponding serial numbers.

The MAS refers to the green bar authorization number report provided by ACS to get the next available authorization number. The MAS hand writes the authorization number on the request form. From the MMIS main menu, the MAS enters the "11" screen, for Prior Authorization input, and enters the authorization number with the Client's PIC number. Once the MAS presses enter, the Prior Authorization detail screen is opened. The MAS verifies eligibility and coverage information in MMIS with a series of questions:

Is the Client currently eligible?

NO: The MAS faxes the request back to the provider with a cover letter explaining that the Client is not eligible for Medicaid assistance.

YES: Is there Medicare or managed care?

YES: The MAS faxes the request back to the provider with a cover letter explaining that the request needs to be submitted to the other carrier prior to Medicaid consideration.

NO: Is this DME or Supply on the list for PA per the billing instructions?

NO: The MAS faxes the request back to the provider with a cover letter explaining that this item does not require prior authorization.

YES: The MAS checks MMIS prior authorization and claim history for related treatment or services. If there is history, the MAS documents the details on the intake sheet.

At this point, The MAS enters the status and the remaining details from the request form into the MMIS authorization screen. The MAS attaches all of the details to the file and forwards the request to the MAS3 for the DME decision-making process.

4.3.2.3 DME Prior Authorization Decision Making

The MAS3 first determines if there is enough information to make an appropriate authorization decision. If further information is needed from the Client's physician or the supplier, the MAS3 keys the decision into MMIS and routes the file back to the MAS2. The MAS2 completes a form indicating what is needed and takes the folder to the file room for faxing. The OAS faxes it to the provider and/or supplier, makes copies for the client and files the folder back in master file room, until the additional information is received. The OAS creates labels and mails a copy of the request to the client. Once the information is received, the file returns to the intake process.

If the MAS3 has determined that there is enough information to perform an authorization review, the details are applied to established business rules and criteria. The Clinical staff have predetermined these rules and criteria based upon medical necessity and application to the WAC (Washington Administrative Code). At this point, the MAS3 makes a decision and determines the pricing. In order to calculate the pricing, the MAS3 accesses the DME pricing database, the manufacturers pricing guides, or the Internet for allowable prices. The MAS3 writes the authorization decision (approved/denied), the pricing, reference information used for the decision, and any relevant notes on the request form. The MAS3 then keys the decision into MMIS and routes the request form to the file room for faxing. The OAS faxes the request form to the provider and/or supplier and re-files the folder. If the request is to be denied, the MAS3 sends the file to the DME Advisory Committee to be reviewed at a higher level.

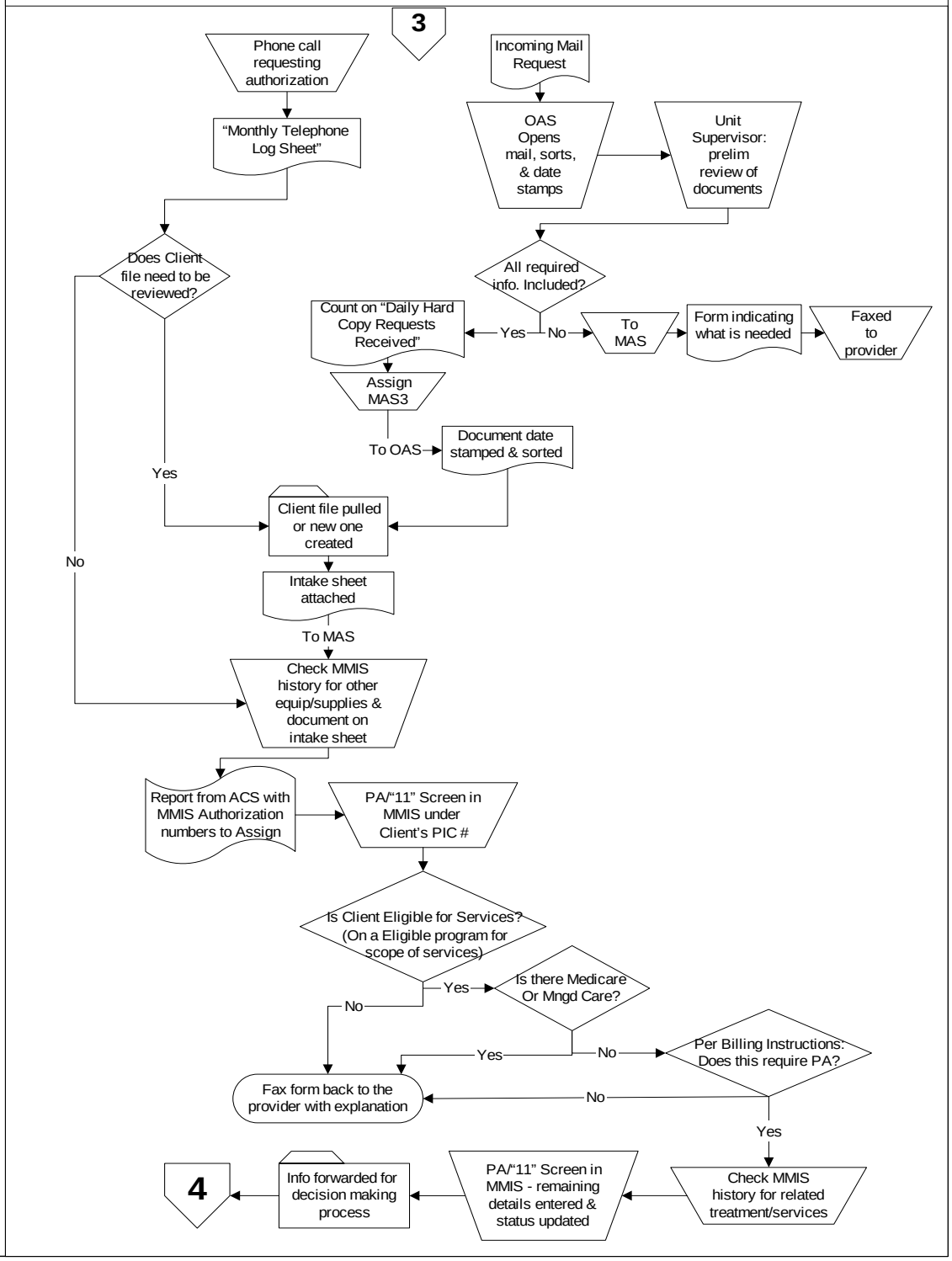
At this point, the MAS3 enters the details into the MMIS authorization screen. If the decision was made during a telephonic request, the MAS3 explains the decision to the caller and if approved, gives the authorization number. If the decision is for a denied telephonic request or is a mailed in request, the MAS3 routes the information to the MAS.

For time-limited approvals, the MAS creates the decision letter through a letter merge process and includes the terms of the purchase or rental in the letter. After the Unit Supervisor signs the decision letter, the OAS copies the letter and faxes a copy to the supplier and mails the original to the client.

For denials, the MAS creates the denial decision letter through a letter merge process and includes the reason for denial and WAC citation in the letter. After the Unit Supervisor signs the denial decision letter, the OAS copies the letter and faxes a copy to the supplier and mails the original to the client. If denied, the MAS logs the denial details into the denial database for tracking and cost saving management reports.

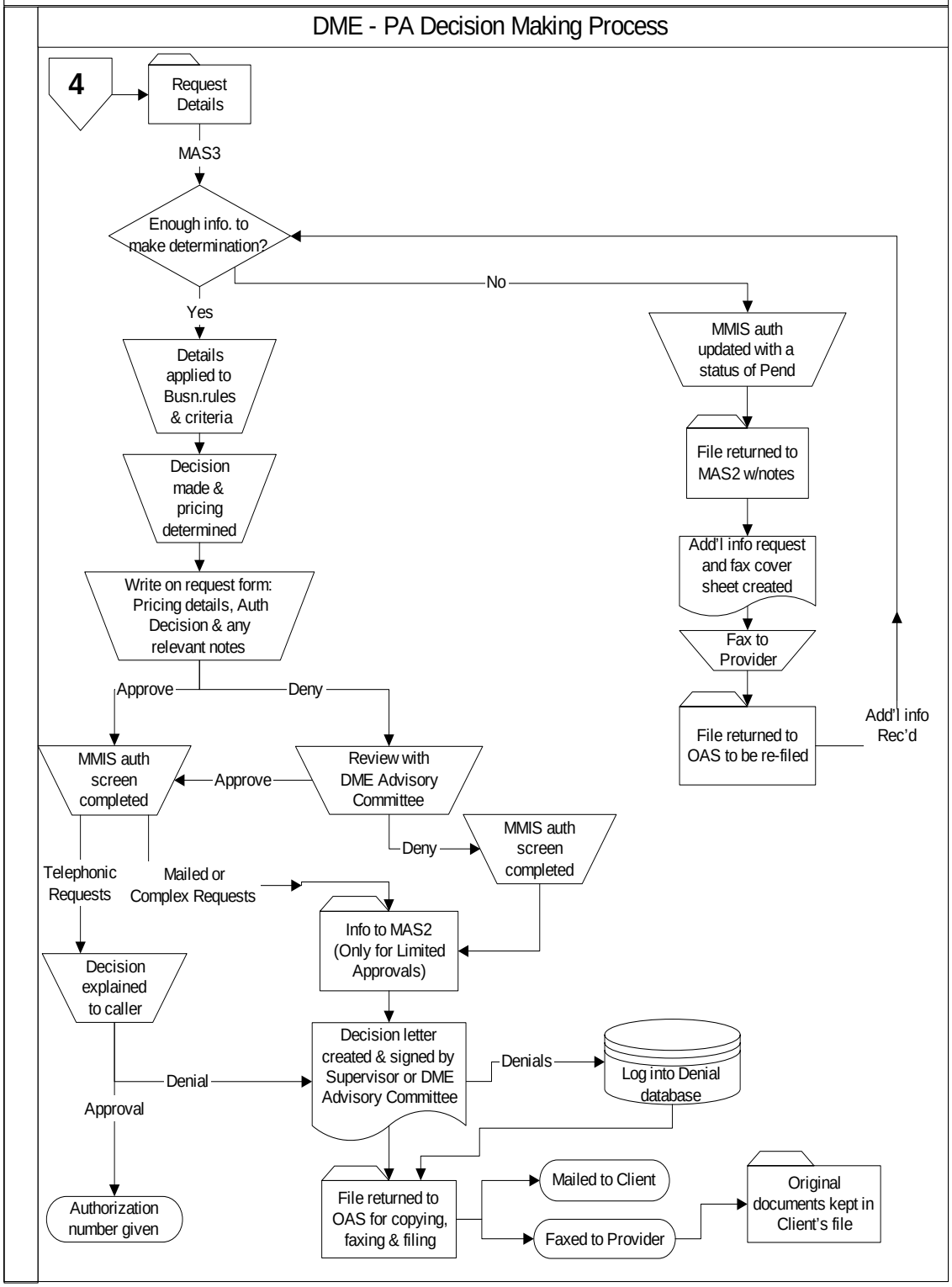
DME (Durable medical equipment) Program Management

DME Authorization Intake Process



DME (Durable medical equipment) Program Management

DME - PA Decision Making Process



4.3.3 Pharmacy

The Medicaid pharmacy coverage is administered through a separate MMIS system referred to as the POS (Point of Sale) MMIS. This system allows Pharmacies to have 'real time' access to Client's eligibility and coverage information through multiple user interfaces. Each prescription drug has a set or sets of criteria assigned to it, and these combinations translate to system codes and edits that are entered by the MMIS Services unit and ACS. Each drug code is assigned a rate that is determined through an MAA pricing algorithm managed by First Databank. These rates are referred to as the SMAC (State Maximum Allowable Cost) or the AMAC (Automated Maximum Allowable Cost). If the pharmacy needs to "waive the MAC" (extend the assigned rate beyond the allowable), or dispense a drug that is not on the formulary or is being denied by another system edit, an authorization is needed. The need for an authorization is communicated to the pharmacy when processing the drug and Client information into the real time interface to the MMIS POS. Similar to other MAA prior authorization processes, the Pharmacy Program also utilizes EPAs (expedited prior authorizations) for drugs that may ordinarily need an authorization, but under certain predefined criteria, a standard EPA number can be used to allow the prescription. Another cost saving measure for the Pharmacy Program is the Therapeutic Consultation Services (TCS) program, which enables MAA staff pharmacists to oversee certain conditions such as repeated usage or questionable refills, by communicating with the prescribing physician.

When a patient brings a prescription to a retail pharmacy that has a provider agreement with the MAA, the pharmacy enters information about the Client and the prescription into an interface with the POS MMIS. The POS MMIS systematically checks the Client details, performs prescription edits, and determines if the drug is approved or not approved. If the drug is approved, the POS MMIS returns an authorization number and the drug can be dispensed. If the drug is not approved, the pharmacy must determine if there was a data entry error, or if an EPA (Expedited Prior Authorization) can be applied to this particular drug. If neither resolution can be applied, the Pharmacy must communicate an authorization request to Pharmacy Program Services.

The Pharmacy may telephone the Pharmacy Services Authorization Unit during MAA working hours or send a request by fax. If faxed, the Pharmacy Services Authorization Unit's Right Fax system receives the request. Right Fax holds the request until a MAS from the Pharmacy Services Authorization team retrieves it for review. Once the MAS receives the request for PA, they enter Client, prescribing physician, diagnosis and drug information into the POS MMIS. The MAS utilizes a local drug database to review predefined MAA drug criteria. At this point, the MAS determines which of the following paths the request must take:

<u>If the Client/drug information does not meet the criteria or the drug is not in the drug database</u>: The MAS routes the request to DURT (Drug Utilization Review Team). DURT reviews, makes a decision and forwards back to the MAS staff to complete the decision process. If the drug information was not in the database, DURT sets the criteria to be added to the database.

If there is further information needed from the prescribing physician: the MAS enters a pend status in MMIS and faxes a request form to the prescribing physician to advise of the information needed to be faxed. If the prescribing physician does not send the information needed, the prescription will be denied. If the prescribing physician does send the information, all variables are reconsidered in the decision process.

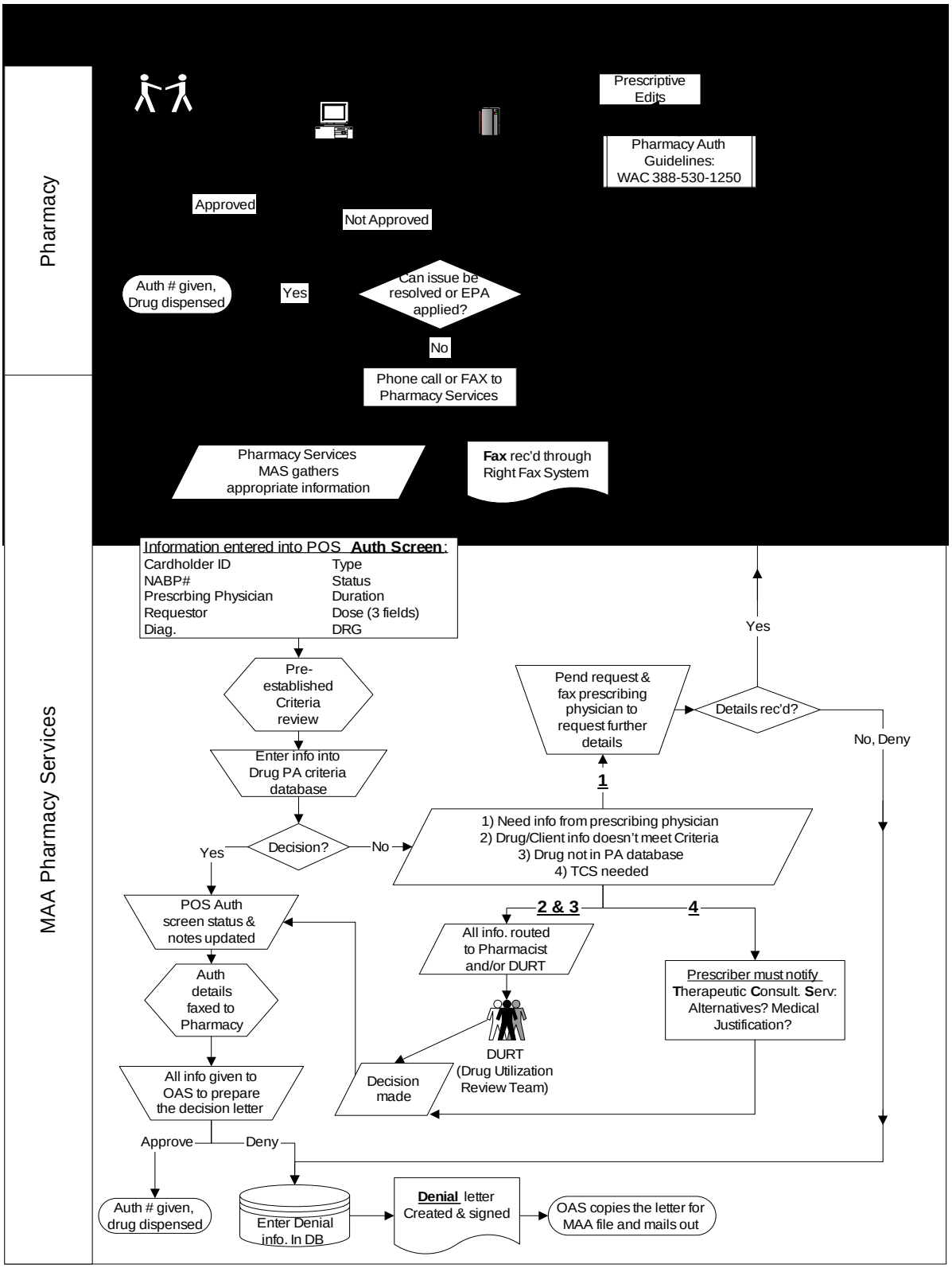
If TCS is needed: Pharmacy Program Services advises the pharmacy that the prescribing physician must contact TCS (Therapeutic Consultation Services) to discuss any alternatives or medical justification, prior to an authorization determination can be made.

Approved or Denied

When Pharmacy Program Services makes a determination to approve or deny, the MAS accesses the POS system to update the authorization with all of the details and notes. The MAS hand writes the details on the request and forwards all documents to the OAS.

For Approvals, the authorization number is faxed back to the Pharmacy to be used to complete the POS MMIS transaction and dispense the drug.

For denials, the MAS faxes the denial information to the pharmacy, enters the details into MMIS and routes the documents to the OAS to be entered into the Denial database. The OAS creates a denial letter and routes to MAS staff for signature, and then sends a copy of the letter to the Client. The OAS files all of the original documentation together in the event of a fair hearing request.


Pharmacy
MAA Pharmacy Services
Prescriptive Edits
Pharmacy Auth Guidelines: WAC 388-530-1250
Approved
Not Approved
Auth # given, Drug dispensed
Yes
Can issue be resolved or EPA applied?
No
Phone call or FAX to Pharmacy Services
Pharmacy Services MAS gathers appropriate information
Fax rec'd through Right Fax System
Information entered into POS Auth Screen:
Cardholder ID
NABP#
Prescrbing Physician
Requestor
Diag.
Type
Status
Duration
Dose (3 fields)
DRG
Pre-established Criteria review
Enter info into Drug PA criteria database
Decision?
Yes
No
1) Need info from prescribing physician
2) Drug/Client info doesn't meet Criteria
3) Drug not in PA database
4) TCS needed
1
Pend request & fax prescribing physician to request further details
Details rec'd?
Yes
No, Deny
2 & 3
4
All info. routed to Pharmacist and/or DURT
DURT (Drug Utilization Review Team)
Decision made
Prescriber must notify Therapeutic Consult. Serv: Alternatives? Medical Justification?
POS Auth screen status & notes updated
Auth details faxed to Pharmacy
All info given to OAS to prepare the decision letter
Approve
Deny
Auth # given, drug dispensed
Enter Denial info. In DB
Denial letter Created & signed
OAS copies the letter for MAA file and mails out

4.3.4 Dental

Certain dental services, such as dentures, require a prior authorization. Prior to rendering a dental service to a Medicaid Client that, according to the WAC, requires prior authorization, the dental provider must fax or mail an ADA claim form with all charges listed. The ADA form has a field for the provider to indicate that this is a prior authorization versus a claim for actual services. Once the service is authorized, this form can be submitted for payment. The dental prior authorization unit consists of MAS (Medical Assistance Specialists) and MAA Dental Consultants, who all participate in the authorization process.

When the Dental Prior Authorization unit receives a request, the OAS date stamps, sorts, and routes it to the MAS staff. The MAS reviews the request to determine if it is for a removable dental device. If it is, the MAS reviews the Client's MMIS history to determine if a removable device has ever been paid for this Client. On-line MMIS claims history is often insufficient to support this determination and requires research based on a client-specific system-generated report that must be requested by the MAS. Once this information is gathered, it is documented and attached to the request. The MAS opens two sessions of MMIS, one to enter the information in the Authorization screen and a second to verify eligibility and coverage.

On the first MMIS session, similar to other MMIS prior authorization processes, the MAS opens the Prior Authorization "11" screen. The MAS retrieves an authorization number from the green bar authorization number report provided by ACS. The MAS enters the authorization number and the Client's PIC into the detail screen. On the second MMIS session, the MAS researches various Client information to make a determination, and all relevant information that is gathered is attached to the request and is considered "back-up" documentation:

Is the Client currently eligible for Dental Program services?

NO: The MAS faxes the request back to the provider with a cover letter explaining that the Client is not eligible. No authorization number is given.

YES: Is there any relevant dental claim history?

YES: The MAS attaches screen prints as back up documentation.

NO: **Decision -** Does this service meet criteria for coverage based on MAS delegated authority?

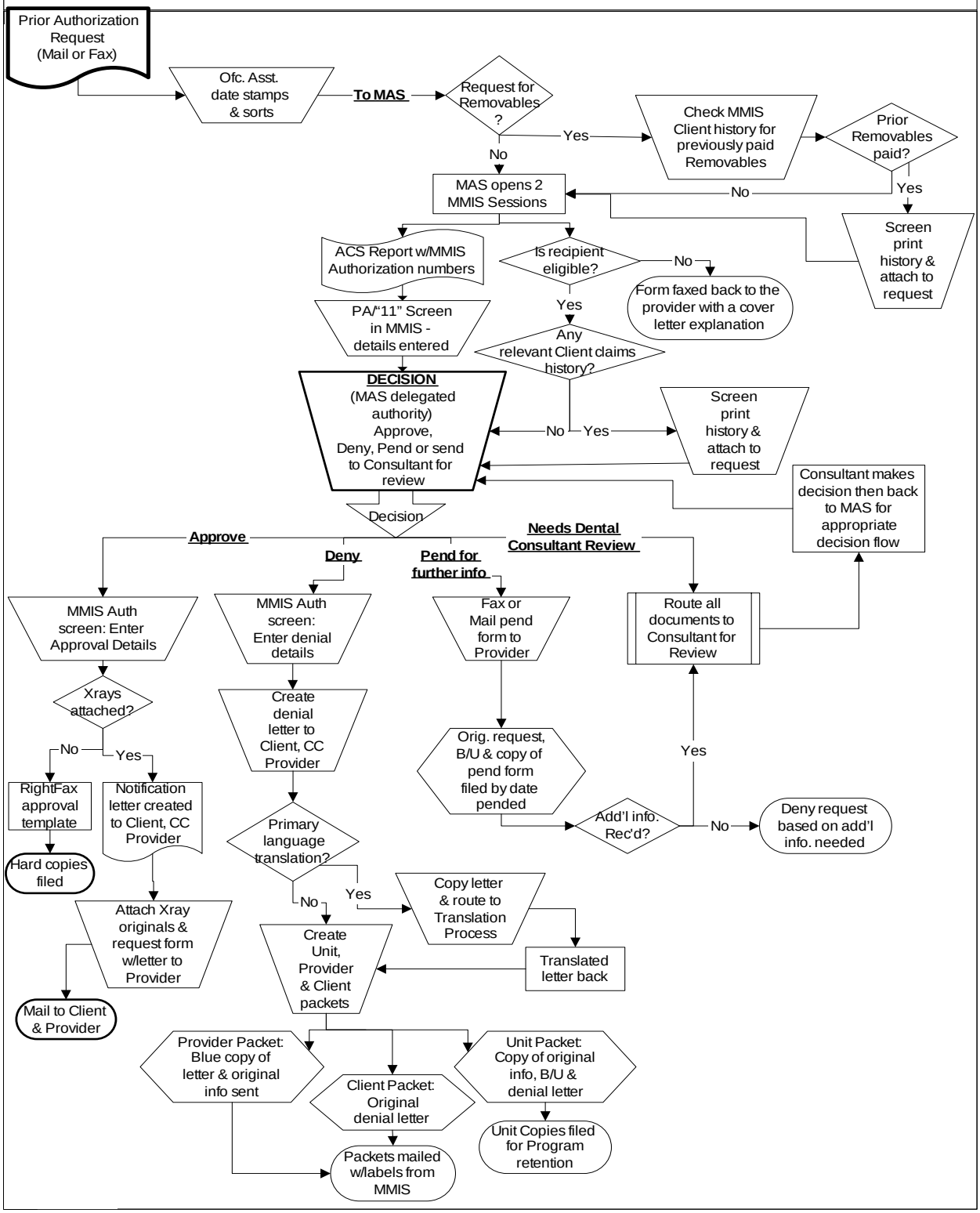
Need further information: The MAS updates the MMIS authorization screen with a pended status and documents the information needed in the notes. At that point the MAS faxes the request back to the dental provider with a fax cover letter explaining the additional information is needed to process the request. The documents are filed in a thirty-day tracking folder for follow up. Once the information is received, the MAS reviews the request again. If the information is not received within the thirty days, a denial letter explanation is faxed or mailed to the Provider.

Denied: The MAS updates the authorization detail screen with the denied status and documents, in the note section, that the service does not meet established criteria. The MAS creates a denial letter and determines if a primary language translation is needed. If a translation is needed, the MAS or the OAS makes a copy of the letter and forwards it to the translation process. Once the letter is translated and for letters that don't need translated, the MAS or OAS makes one white copy and one blue copy of the denial letter. The MAS or OAS sends the original letter to the Client and the blue letter, with the original information to the provider, and copies of all documents are filed in the Unit's denial file system.

Approved: The MAS documents the back up information in the MMIS Authorization screen notes and enters an approved status. If the x-rays were sent in with the original request, the MAS creates an approval letter, makes a two copies of the letter and a replacement set of the x-rays. The MAS or OAS mails the original letter to the Client and a copy with the original x-rays to the Provider. A copy of the letter, the original information and other back up documentation is filed in the Unit's file system. If the x-rays were not sent with the original request, the MAS enters the approval information into the RightFax approval template and sends the fax to the Provider. The Client would not receive an approval letter.

To Dental Consultant for review: The MAS forwards all of the documentation to the Dental Consultant for review. Once a decision has been made, the Consultant returns the documents to the MAS for appropriate processing (according to above decisions of either approved, denied or pended for further information).

Dental Prior Authorization



4.3.5 Transportation Services

Transportation and Interpreter Services Section (TISS), within the Division of Customer Support provides services to ensure that Medicaid Clients have equal access to medical care. Even though a large majority of services covered through TISS are handled through MAA contracted brokers, the TISS Program Managers coordinate authorizations and payments for out of state transportation and vehicle devices. The Program Managers receive incoming phone calls, written requests by fax, mail and email from Clients, hospital discharge planners, transportation brokers, and other individuals or organizations attempting to coordinate services.

4.3.5.1 Out-of-State Transportation

When a Medicaid Client is authorized for an out of state service or receives emergency services while out of state, there may be a need for transportation services, food and lodging. Transportation Services has an authorization process that is followed when these services are requested; however, no MMIS authorization number is generated and the payments are issued via A-19 once the services are rendered.

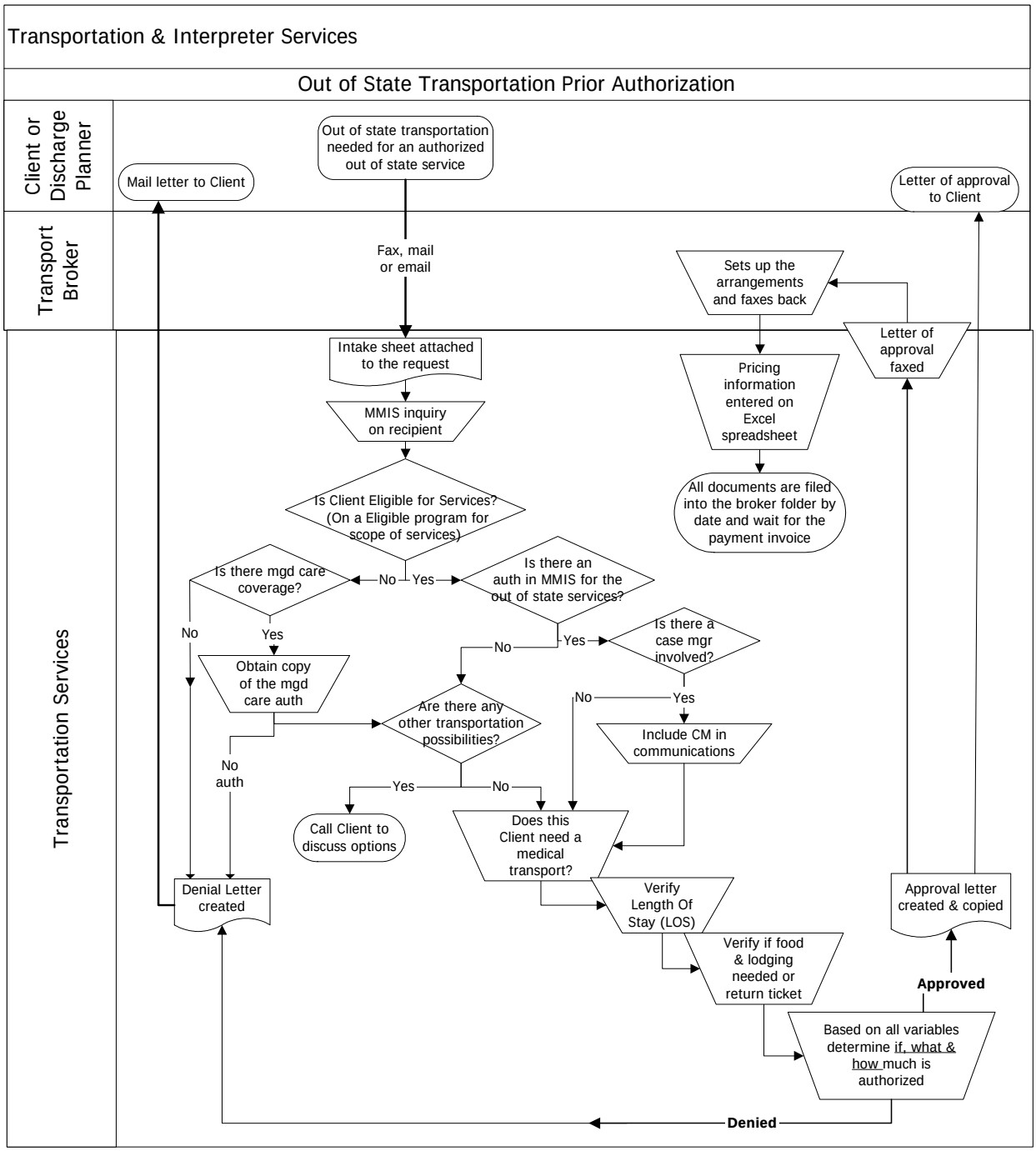
Prior to seeking out of state transportation, the Client or representative of, is required to request authorization in writing. The Client can fax, mail or email the request directly to Transportation Services. Once the request is received, the program manager attaches an intake sheet that is used to document the authorization details and Client information. The program manager utilizes a series of steps and inquiries into MMIS:

Is the Client currently enrolled in an eligible MAA Program?

NO: Is there a managed care program liable for coverage?

NO: The Program Manager creates a denial letter with an explanation and sends it to the Client.

YES: The Program Manager obtains a copy of the managed care program's authorization and continues with the intake screening and transportation arrangements.



YES: Are there any other transportation possibilities?

YES: The Program Manager telephones the requester to discuss details and other possibilities.

NO other transportation possibilities: The Program Manager reviews the arrangements and request variables needed for the authorization:

Is this a medical transport or will standard transportation arrangements be sufficient?

Is there a case manager involved that needs to be included in the communication?

What is the length of stay?

Is there a need for food, lodging and a return trip?

Once all of these variables are determined, the Program Manager either approves or denies the request. The program manager creates a decision letter and sends it to the Client. If approved, the program manager retains a copy of the letter and faxes it to the transportation broker that is located in the Client's area so that arrangements can be made. The broker then sets up the arrangements and faxes it back to the program manager with pricing information. The program manager enters the pricing into an Excel spreadsheet and files all of the details alphabetically by broker. Once all services have been rendered, the transportation broker invoices Transportation Services for payment.

4.3.5.2 Vehicle Devices

Prior to obtaining a vehicle modification, ramp or lift, or a driving assistance device, a Medicaid Client must submit a written request to Transportation Services. The authorization process requires the Program Manager to make numerous phone calls to the Client and to the transportation broker to ensure that all of the inspections and installations are handled appropriately. Similar to out of state transportation prior authorizations, no MMIS authorization number is generated and the payments are issued via A-19 once the services are rendered. The authorization must be approved and a letter signed by the Program Director.

The Client faxes, mails or emails the written request to Transportation services. Once the request is received, the program manager attaches an intake sheet that is used to document the authorization details and Client information. The Program Manager makes a series of inquiries in MMIS:

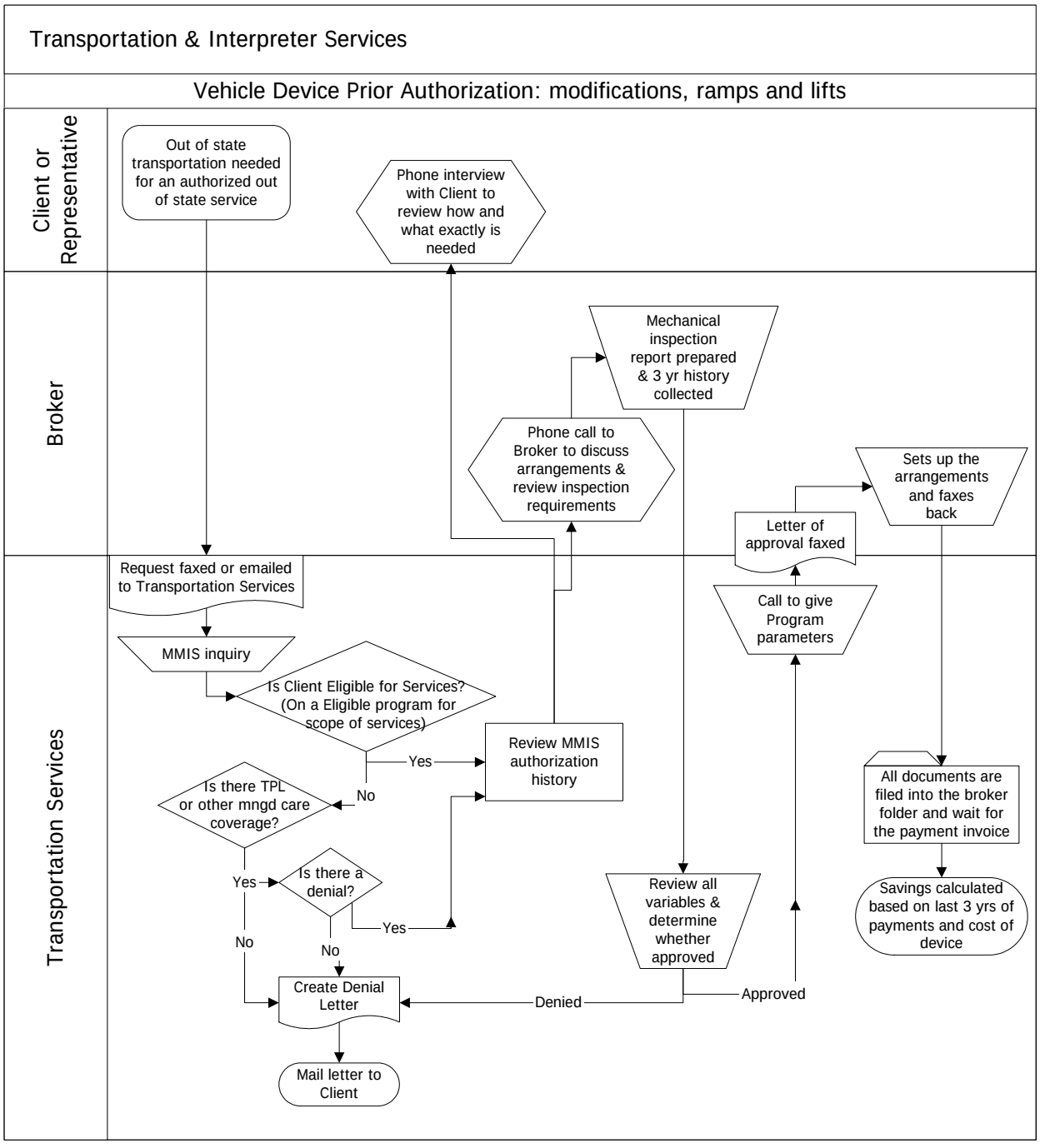
Is the Client currently enrolled in an eligible MAA Program?

NO: Is there a third party liability or managed care program coverage?

NO: The Program Manager creates a denial letter with an explanation and mails to the Client.

YES: The Program Manager contacts the requester to notify that the other liability must consider the request first.

YES: The Program Manager reviews MMIS for authorization and claim history. Once the details are gathered, the program manager telephones the Client for an interview to discuss the specifics about the vehicle and determine which broker will be used. The Program Manager makes a second phone call to the broker to discuss arrangements, history and inspection requirements.

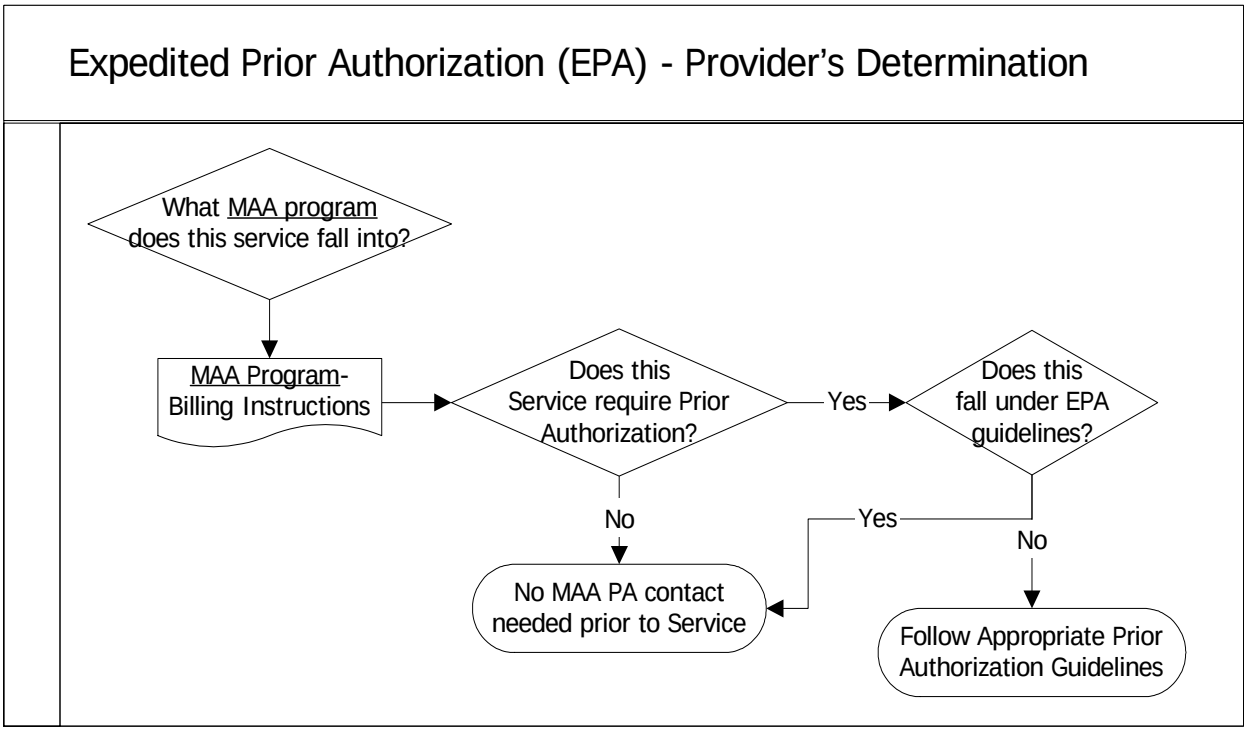


The transportation broker is required to submit a three-year history for cost savings calculations, and a mechanical inspection of the Client's vehicle before an authorization decision can be made. The Program Manager considers the cost savings and medical need and makes a determination of approved or denied. If denied, the Program Manager creates a denial letter and mails it to the Client. If approved, the Program Manager telephones the broker to explain the program's approval parameters and faxes the approval letter. The transportation broker

sets up the arrangements and faxes the pricing details back to Transportations Services. At that point, the Program Manager enters the pricing and three year history information into the savings spreadsheet and files the documents alphabetically by broker.

4.3.6 Expedited Prior Authorization

Each MAA Program's General Information Booklet describes certain services, drugs, equipment and supplies that fall into the category of expedited prior authorization (EPA). An EPA, as defined in the MAA's September 2000 General Information Booklet, is "the process of authorizing selected services in which providers use a set of numeric codes to indicate to MAA which acceptable indications, conditions, diagnoses, and/or criteria are applicable to a particular request for services"(2). The intent of an EPA is to streamline the authorization processes for established criteria with specific coding and allow the providers to make their own authorization determination for those services. This process enables providers to use an assigned EPA number on their claims in the PA field, when appropriate.



As indicated previously in other Prior Authorization Sections, prior to rendering services to a Medicaid Client, the provider must first determine if the service requires prior authorization. If prior authorization is required, the provider can refer to the Billing Instructions to determine if the proposed service qualifies for expedited prior authorization, based on established guidelines. If so, the provider does not need to pursue communication to the MAA Prior Authorization Departments. The provider can send the claim to MAA once the services are rendered, with the

expedited prior authorization number from the billing instructions, in the claim's 'authorization' field.

5. Provider Enrollment

5.1 Overview

The Provider Relations Section, organizationally, falls under the MAA's Division of Customer Support. This Section consists of a Manager, three Medical Assistance Specialists (MAS) that coordinate provider enrollments and four MAS4 staff that provide education and provider support throughout the state. The Provider Enrollment Unit handles a wide variety of new and existing provider, group and facility enrollments for all of the DSHS Programs that are administered through MMIS; however, there currently is not a policy or process for licensure or background verification in this area.

The business process reviews described below, have been separated by new provider enrollments, existing provider updates/re-enrollments, disenrollments and special provider types. Special provider types consist of sign language interpreters, tribal physicians and other providers who, dependent upon the Program, may not follow traditional MAA guidelines to provide services to Medicaid Clients.

5.2 Business Functions

5.2.1 Provider Enrollment Process

The provider enrollment process starts with a provider either making the determination to start providing services to Medicaid Clients, or with one that has already provided services, i.e. out of state emergency services. The provider completes an enrollment packet, which contains a Core Provider Agreement, which contains general guidelines and requirements, an enrollment application, which contains an ownership disclosure, and a section of Frequently Asked Questions about debarment with the debarment form. Once the provider has completed the packet, he attaches a copy of the current licensure and submits by mail to the Provider Enrollment Unit. The licensure can be either a professional license for a physician, or a business license for products and equipment providers. The packet of completed documents remains on file, electronically through a software application named KoVIS, for the Provider Relations Section to reference when needed.

With the exception of special provider types that are not paid through MMIS, prior to receiving payment for services to a Medicaid Client, a provider or facility must be enrolled through the Provider Enrollment Unit. Since Medicaid does cover certain physicians and clinics without imposing all of the enrollment guidelines, such as out of state physicians, or maternity support services, not all providers enrolled in MMIS have been through the same enrollment process. Even though these occurrences do cause exceptions to the provider enrollment policy, the standard guideline is that no provider of service is enrolled into MMIS without receiving all of the required documentation.

5.2.1.1 New Enrollments

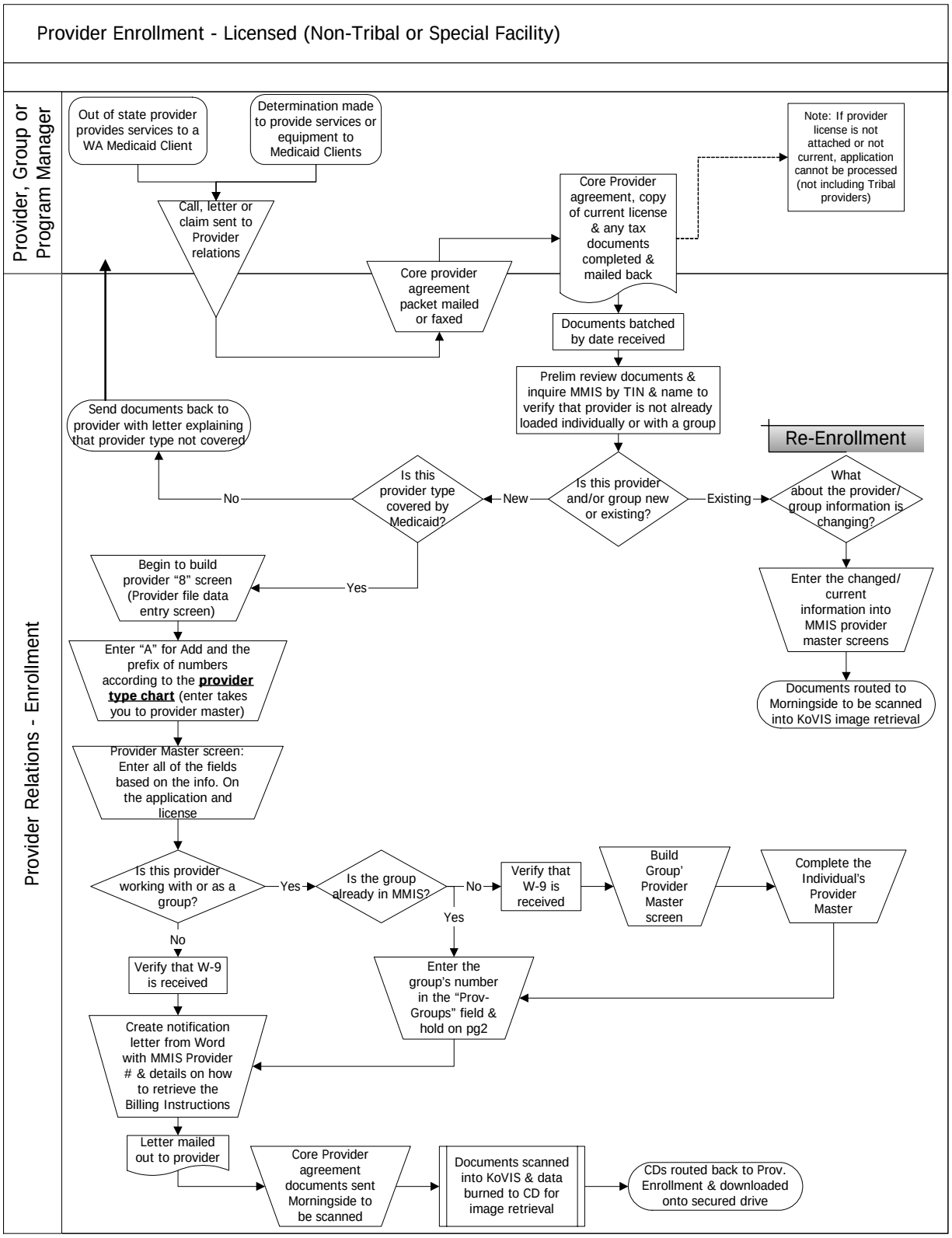
The new provider enrollment process can begin several ways. When interested in becoming a Washington State Medicaid Provider, the provider can telephone, fax, send a letter to the Provider Relations area, or send a claim for services. Regardless of the mode of communication, if they have not completed the Core Provider Agreement packet, the Provider Enrollment Unit mails the required paperwork to the provider to be completed. Upon receipt of the documentation needed to enroll a new provider into MMIS, the provider enrollment MAS date stamps and files the documentation by date to be reviewed in the order in which it was received.

The MAS reviews the documents to ensure they are complete and inquires into MMIS by tax ID number or name to verify that the provider and/or group is not already loaded in MMIS. The MAS verifies that the provider requesting enrollment is considered a Medicaid covered provider type. If the provider is not a covered provider type, the documents are sent back to the provider with a brief explanation.

Once verified that the documents are for a new (covered) provider enrollment, the MAS clarifies how the provider's payment arrangements are structured and opens the Provider File entry, "8", screen. From here the MAS enters an "A" to add and enters the prefix of numbers that corresponds with the provider type chart, which is a standard "intelligent number" system used to help identify providers by type. This intelligent number also corresponds with whether the provider is considered performing or billing, for payment purposes. Once the MAS presses enter, the MMIS systematically completes the remaining digits in the provider ID number and opens the Provider Master screen. The MAS enters all of the demographic and payment information from the application. If the provider is working under a group, the MAS determines if that group is already in MMIS, or if the group needs to be added as well. Every group, electronic submitter, performing provider, facility, etc., must have a separate provider number due to the current MMIS constraints. Under group payment arrangements, page two of the performing provider's record indicates a payment hold and references the billable provider ID number.

If the new provider is not working with a group or if the group is not already in the MMIS, the MAS verifies that the current W-9 tax information is attached and enters the application details into the Provider Master screen. For new groups, the MAS enters the group provider number as a cross reference in the "Prov-Groups" field on the individual provider's screen.

When all of the provider and/or group information has been entered and the new MMIS provider numbers are established, the MAS creates a letter with reference to the new provider number and how to retrieve the online Billing Instructions. The MAS mails the letter to the provider and sends all of the application documents to Morningside, who contracts with MAA for various administrative and scanning functions. Morningside scans the documents into the KoVIS application and burns each day's data to CD-ROM. Morningside routes the CD-ROMS back to provider enrollment. Provider enrollment saves the data onto the Departments secured drive, so that the images can be accessed as needed from their desktop PCs.


Provider Enrollment - Licensed (Non-Tribal or Special Facility)
Provider, Group or Program Manager
Provider Relations - Enrollment
Out of state provider provides services to a WA Medicaid Client
Determination made to provide services or equipment to Medicaid Clients
Call, letter or claim sent to Provider relations
Core provider agreement packet mailed or faxed
Core Provider agreement, copy of current license & any tax documents completed & mailed back
Note: If provider license is not attached or not current, application cannot be processed (not including Tribal providers)
Documents batched by date received
Prelim review documents & inquire MMIS by TIN & name to verify that provider is not already loaded individually or with a group
Send documents back to provider with letter explaining that provider type not covered
Re-Enrollment
Is this provider and/or group new or existing?
New
Existing
What about the provider/ group information is changing?
Is this provider type covered by Medicaid?
No
Yes
Begin to build provider "8" screen (Provider file data entry screen)
Enter the changed/ current information into MMIS provider master screens
Documents routed to Morningside to be scanned into KoVIS image retrieval
Enter "A" for Add and the prefix of numbers according to the provider type chart (enter takes you to provider master)
Provider Master screen: Enter all of the fields based on the info. On the application and license
Is this provider working with or as a group?
Yes
No
Is the group already in MMIS?
No
Yes
Verify that W-9 is received
Build Group' Provider Master screen
Complete the Individual's Provider Master
Verify that W-9 is received
Enter the group's number in the "Prov-Groups" field & hold on pg2
Create notification letter from Word with MMIS Provider # & details on how to retrieve the Billing Instructions
Letter mailed out to provider
Core Provider agreement documents sent Morningside to be scanned
Documents scanned into KoVIS & data burned to CD for image retrieval
CDs routed back to Prov. Enrollment & downloaded onto secured drive

5.2.1.2 Re-Enrollments

Prior to the current year, Medicaid providers were not required to re-enroll or to keep their Core Provider Agreements current. But since part of the provider's responsibility as a Medicaid provider is to keep the demographic and tax payer information current, re-enrollment efforts have been made through provider enrollment.

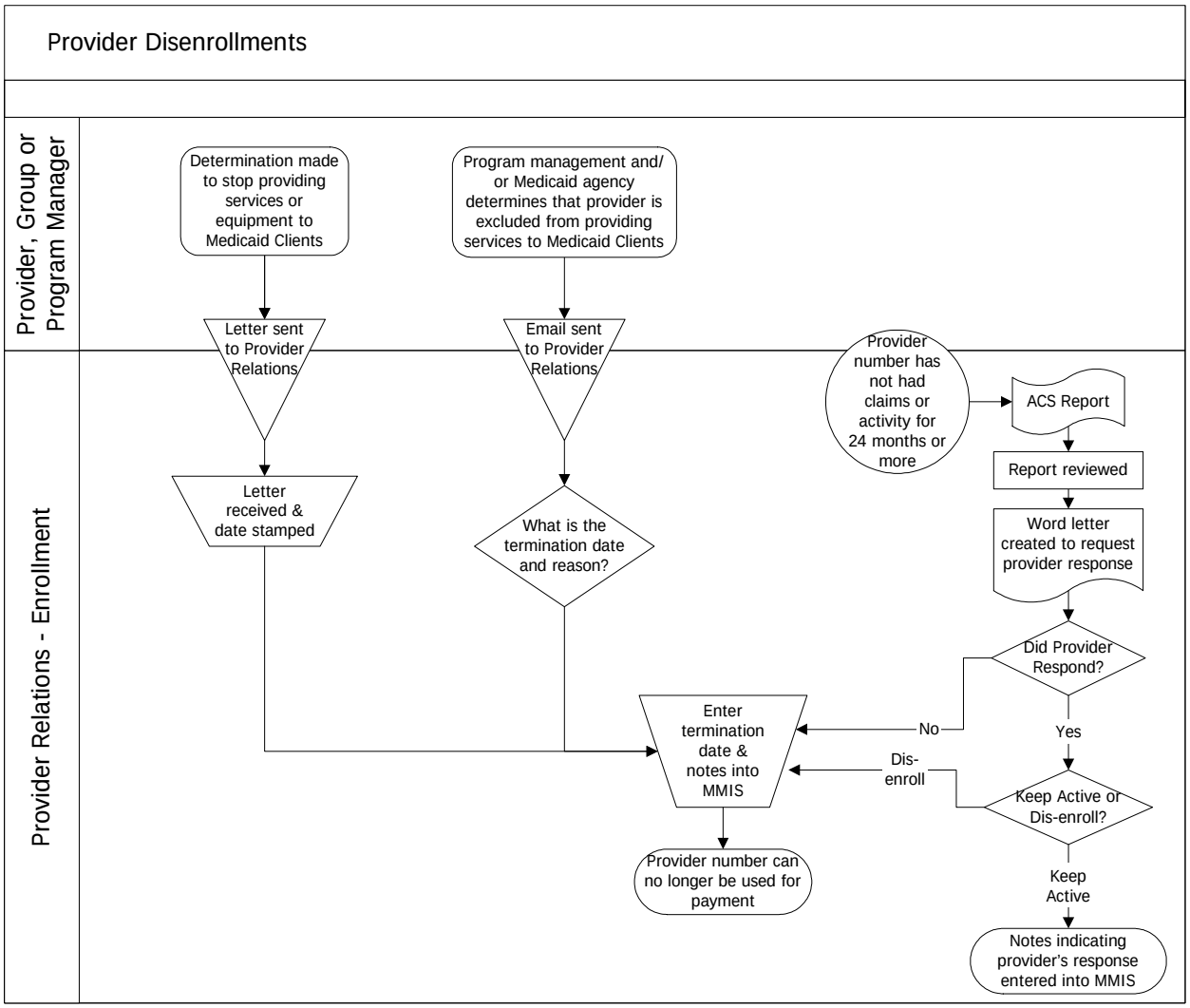
For existing providers who have not yet re-enrolled, the provider enrollment section mails a Core Provider Agreement packet. Once the provider has completed the forms and attaches copies of any license or tax information needed for re-enrollment, the documents are mailed to Provider Relations. The Provider Enrollment area, date stamps and batches all received mail so that it can be reviewed sequentially. Once the MAS has verified that this is a provider re-enrollment, she completes a review of all documents submitted and compares the information to the provider's MMIS records. The MAS determines what is new or updated and enters this information into MMIS. The MAS routes all documents to Morningside to be scanned into KoVIS and burned to CD for retrieval.

5.2.1.3 Disenrollments

A Medicaid provider can be excluded from providing services to Medicaid Clients, whether voluntary or involuntary. If the provider chooses to no longer provide services to Medicaid Clients, he must mail a letter indicating his request to Provider Relations. When Provider Relations receives the provider's request to voluntarily disenroll, the MAS date stamps the letter and enters a termination date and notes into MMIS. The MAS forwards the letter to Morningside to be scanned into KoVIS. At this point, the provider number can no longer be used for payment.

A provider may be involuntarily disenrolled for one of two reasons. The first is for a period of claim inactivity of 24 months or more. A report from ACS is reviewed by provider enrollment and the MAS sends a letter to the provider advising of the upcoming disenrollment. If the provider does not respond to the letter or responds indicating that disenrollment is requested, the MAS enters a termination date and notes into MMIS. The MAS forwards any documentation obtained, to Morningside to be scanned. At this point, the provider number can no longer be used for payment, and the record is terminated.

The second reason a provider can be involuntarily disenrolled is when a DSHS Program, OIG (or other Medicaid Agency determines that the provider should be excluded from providing services to a Medicaid Client. When this is determined, the Program Manager sends an email with the requested disenroll date and reason to the provider enrollment section. Upon receipt of this information, the MAS enters the date and notes into MMIS and the provider's number is no longer active for payment.



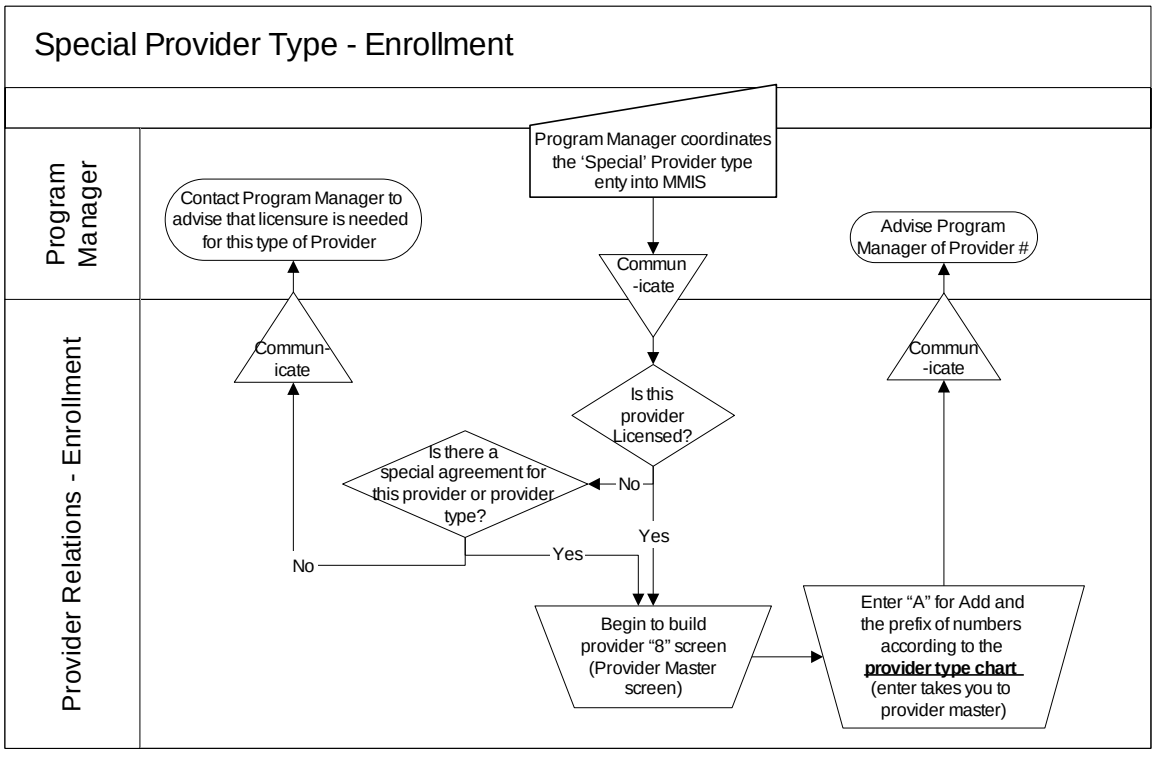
5.2.2 Special Provider Types: Enrollment Process

In order to provide coverage for certain services to Medicaid Clients, some of the DSHS Programs that are administered through MMIS, have different requirements for providers to be considered covered. One of these provider types is an American Sign Language (ASL) interpreter. Individual ASL interpreters do not hold a contract directly with DSHS; they work through an agency that holds a contract with the General Administration (GA). The interpreters are enrolled into MMIS without a license, but all payments are made to the contracted agency. Since the agencies are awarded a service contract through an RFP bidding process, the agency list does not change, however; the interpreters can work through multiple agencies. Because of this arrangement, the enrollment process for ASL interpreters is coordinated through the Transportation and Interpreter Services Section (TISS).

Other types of providers that may not be individually licensed or covered under traditional Medicaid, but still need to be enrolled in MMIS are tribal clinics, birthing facilities, rural health clinics and federally qualified health centers. These special provider type enrollment arrangements are coordinated through the DSHS Program Manager.

5.2.2.1 Special Provider Agreements

When a special provider types are or will be providing services to Medicaid Clients, the Program Manager coordinates the effort with Provider Enrollment staff. The Provider Enrollment MAS verifies with the Program Manager, how this new provider is licensed, if a licensure exists, and if there is a special provider type arrangement for this provider. With this information and the Provider Agreement, the MAS begins building the provider into MMIS through the Provider Master "8" screen. The MAS uses the provider type as indicated on the Provider Type Chart for the prefix of the provider and completes the MMIS data entry portion of the enrollment process. Once the provider number is assigned, the MAS sends a follow up email back to the Program Manager so that the provider can be contacted. If there is not a special agreement for enrollment of this provider type, the MAS emails the program manager to advise of the guidelines established that mandate that this provider type have a licensure prior to rendering services to a Medicaid Client.

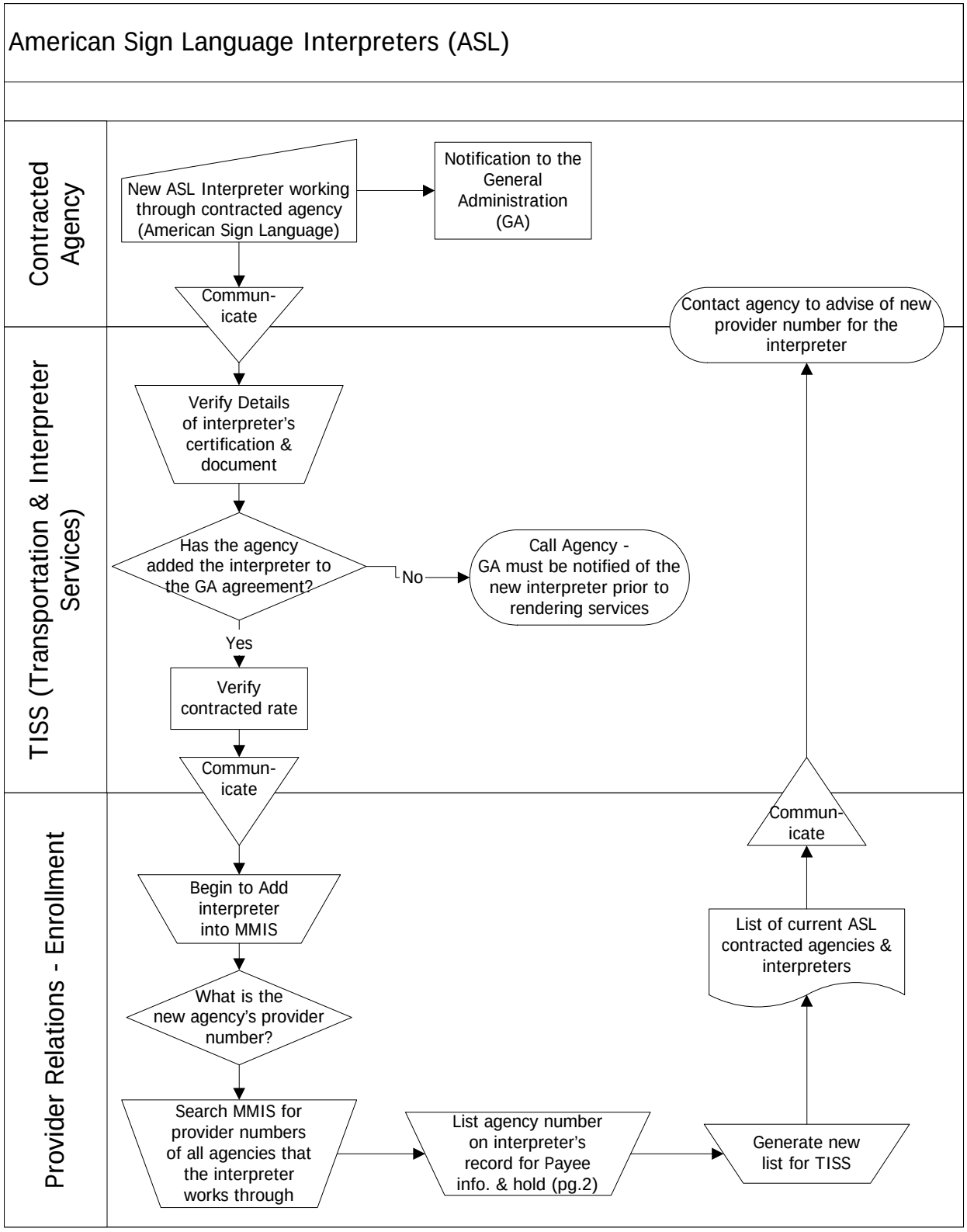


5.2.2.2 American Sign Language (ASL) Interpreters

When a Medicaid Client needs ASL interpreter services in order to communicate with a Medicaid covered provider of service, the provider contacts one of the ASL contracted agencies listed on the billing instructions. These contracted agencies sub-contract with both certified and non-certified ASL interpreters under a General Administration service contract. When a contracted agency adds a new interpreter, the agency must notify the General Administration and the Transportation and Interpreter Services Section (TISS).

Once the TISS Program Manager receives notification from the contracted agency and the General Administration has been updated with the new interpreter, he gathers further details regarding the individual interpreter. The Program Manager verifies what the contracted rate of payment is for this individual and if this interpreter is also working through any of the other contracted agencies. Once these details are documented, the TISS Program Manager communicates by email to Provider Enrollment.

The Provider Enrollment MAS researches the information provided, to determine if the interpreter is already in MMIS linked to any other agencies. The MAS selects a performing provider number from the Provider Number Chart appropriate for the ASL providers that perform services only. The MAS then begins to add the new information into the Provider Master screens. On the individual's record, the MAS lists the agency or agency's billing provider number(s) as payees and enters the payment hold information, "non-payable/ID only" on page two. The MAS then sends a follow up email to the TISS Program Manager to notify of the new provider number. The TISS Program Manager communicates with the agency regarding the interpreter's provider number and any limitations.


American Sign Language Interpreters (ASL)
Contracted Agency
TISS (Transportation & Interpreter Services)
Provider Relations - Enrollment
New ASL Interpreter working through contracted agency (American Sign Language)
Notification to the General Administration (GA)
Commun-icate
Contact agency to advise of new provider number for the interpreter
Verify Details of interpreter's certification & document
Has the agency added the interpreter to the GA agreement?
No
Call Agency - GA must be notified of the new interpreter prior to rendering services
Yes
Verify contracted rate
Commun-icate
Commun-icate
Begin to Add interpreter into MMIS
List of current ASL contracted agencies & interpreters
What is the new agency's provider number?
Search MMIS for provider numbers of all agencies that the interpreter works through
List agency number on interpreter's record for Payee info. & hold (pg.2)
Generate new list for TISS

6. References

1 Authorizations, “Physician Related Services - Expedited Prior Authorization (EPA)”. Memo 02-32 MAA (Revised July 2002)

2 Medical Assistance General Information Booklet. Pg.F-2. September 2000, http://fortress.wa.gov/dshs/maa/Download/BillingInstructions/GeneralInfo%20Billing%20Manual.pdf

7. Appendix A

Flow Chart Shape Reference